Calendar No. 353

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VETERANS' ADMINISTRATION BENEFICIARY TRAVEL, QUALITY ASSURANCE, AND READJUSTMENT COUNSELING AMENDMENTS OF 1987

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

TO ACCOMPANY

S. 1464

together with

MINORITY VIEWS

September 29 (legislative day, September 25), 1987.—Ordered to be printed

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September 29 (legislative day, September 25), 1987.—Ordered to be printed

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Mr. Cranston, from the Committee on Veterans' Affairs, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany S. 1464]

The Committee on Veterans' Affairs, to which was referred the bill (S. 1464) to amend title 38, United States Code, to provide eligibility to certain individuals for beneficiary travel payments in connection with travel to and from Veterans' Administration facilities, having considered the same reports favorably thereon with an amendment in the nature of a committee substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

Committee Amendments

The amendments are as follows:

Strike out all after the enacting clause as follows:

[SECTION 1. SHORT TITLE; REFERENCE TO TITLE 38, UNITED STATES CODE.

[(a) Short Title.—This Act may be cited as the "Veterans' Beneficiary Travel Reimbursement Restoration Act of 1987".

[(b) References to Title 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

[SEC. 2. VETERANS' ADMINISTRATION BENEFICIARY TRAVEL PROGRAM.

[Section 111 is amended—

[(1) by redesignating subsections (b), (c), (d), and (e) as subsections (c), (d), (e), and (f);

[(2) by inserting after subsection (a) the following new subsection (b):

["(b)(1) Except as provided in subsection (g) of this section and notwithstanding any other provision of law, if, in any fiscal year, the Administrator exercises the authority under this section to make any payments, the Administrator, in such fiscal year, shall make the payments prescribed in this section, subject to any applicable deduction under paragraph (2) of this subsection, to or for the following persons:

["(A) A person receiving benefit under this title for or in connection with a service-connected disability.

["(B) A veteran receiving pension under section 521 of this title.

["(C)(i) A veteran whose annual income, determined in accordance with section 503 of this title, does not exceed the maximum annual rate of pension which would be payable to such veteran if such veteran were eligible for pension under section 521 of this title, or (ii) a veteran who is determined, under regulations prescribed by the Administrator, to be unable to defray the expenses of the travel for which payment under this section is claimed.

["(D) A veteran whose travel to a Veterans' Administration facility was incident to a scheduled compensation and pension examination.

["(E) A veteran whose travel to a Veterans' Administration facility was required to be performed by a special mode of travel and such travel (i) was authorized by the Administrator before such travel was comenced, or (ii) was in connection with a medical emergency of such a nature that the delay incident to obtaining authorization under subclause (i) of this subparagraph would have been hazardous to the person's life or health.

["(2)(A) Except as provided in subparagraphs (B) or (C) of this paragraph, the Administrator, in making a payment under this section to or for a person described in subparagraphs (A), (B), or (C) of paragraph (1) of this subsection, shall deduct from the amount otherwise payable an amount equal to $3.75 for each trip to or from a Veterans' Administration facility.

["(B) In the case of a person who is determined by the Administrator to be a person who is required to make six or more one-way trips to or from a Veterans' Administration facility for needed care or services under chapter 17 of this title during the following calendar month or months, the amount deducted by the Administrator pursuant to subparagraph (A) of this paragraph from payments for trips made to or from such facility during any of such months shall not, except as provided in subparagraph (C) of this paragraph, exceed $22.50 with respect to travel made during such month.

["(C) Whenever the Administrator increases or decreases the rates of allowances or reimbursement to be paid under this section, the Administrator shall, effective on the date on which such increase or decrease takes effect, adjust proportionately the dollar amounts specified in subparagraphs (A) and (B) of this paragraph.";

[(3) in subsection (f) (as redesignated by clause (1))—

[(A) in paragraph (2)—

[(i) by striking out clause (A); and

[(ii) by redesignating clauses (B) and (C) as clauses (A) and (B); and

[(B) in paragraph (4)—

[(i) by inserting "or adjusting amounts" after "rates" the first place it appears; and

[(ii) by inserting "and amounts" after "rates" the third place it appears; and

[(4) by adding at the end the following new subsections:

["(g)(1) With respect to any fiscal year in which the Administrator exercises the authority under this section to make payments, the Administrator shall prior to October 1 of such year make an allocation to each Veterans' Administration medical facility sufficient to enable the head of such facility to make payments during such year to persons entitled to such payments under subsection (b) of this section.

["(2)(A) In any fiscal year in which funds are allocated pursuant to paragraph (1) of this subsection, the head of each such facility, unless granted a waiver pursuant to subparagraph (B) of this paragraph and regulations which the Administrator shall prescribe thereunder, shall utilize such funds, except as provided in subparagraph (C) of this paragraph, solely for the purpose of making payments under this section.

["(B)(i) In any case in which the head of such a facility demonstrates to the Chief Medical Director that, on April 12, 1987, such facility was making payments under this section at levels less than the levels then authorized under this section, the

Chief Medical Director shall waive the provisions of subsection (b) of this section and authorize payments to be made at any such prior level of payment or at any higher level, proposed by such facility head, less than the amounts prescribed in such subsection.

[“(ii) In any other case in which the head of such a facility proposes to make payments under this section at a level less than the amount prescribed in subsection (b) of this section, if the Chief Medical Director determines that making payments at such lesser level would be in the best interests of furnishing care and services to eligible veterans at such facility, the Chief Medical Director may waive the provisions of subsection (b) of this section and authorize payments to be made at the level proposed by such facility head or at any higher level less than the amounts prescribed in such subsection.

[“(C) Any funds which are allocated to a facility pursuant to paragraph (1) of this section for the purpose of payments under this section but which are not expended for such purpose shall be available to the head of such facility for support of other authorized direct-health-care purposes.

[“(h)(1) The Administrator, in consultation and coordination with the Secretary of Transportation and appropriate representatives of veterans' service organizations, shall take all appropriate steps to facilitate the establishment and maintenance of a program under which such organizations or individuals who are volunteering their services to the Veterans' Administration would take responsibility for the transportation, without reimbursement from the Veterans' Administration, to Veterans' Administration facilities of veterans, primarily those residing in areas which are geographically accessible to such facilities, who seek services or benefits from the Veterans' Administration under chapter 17 or other provisions of this title.

[“(2) not later than six months after the date of the enactment of this subsection, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the implementation of this section.”.

and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCE TO TITLE 38, UNITED STATES CODE.

(a) Short Title.—This Act may be cited as the “Veterans' Administration Beneficiary Travel, Quality Assurance, and Readjustment Counseling Amendments of 1987”.

(b) References to Title 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—BENEFICIARY TRAVEL PROGRAM

SEC. 101. VETERANS' ADMINISTRATION BENEFICIARY TRAVEL PROGRAM.

Section 111 is amended—

(1) by redesignating subsections (b), (c), (d), and (e) as subsections (c), (d), (e), and (f);

(2) by inserting after subsection (a) the following new subsection (b):

“(b)(1) Except as provided in subsection (g) of this section and notwithstanding subsection (f)(2)(A) of this section or any other provision of law, if, with respect to any fiscal year, the Administrator exercises the authority under this section to make any payments, the Administrator, in such fiscal year, shall make the payments provided for in this section, subject to any applicable deduction under paragraph (2) of this subsection, to or for the following persons for travel for examination, treatment, or care:

“(A) A person receiving benefits under this title for or in connection with a service-connected disability.

“(B) A veteran receiving pension under section 521 of this title.

“(C)(i) A veteran whose annual income, determined in accordance with section 503 of this title, does not exceed the maximum annual rate of pension which would be payable to such veteran if such veteran were eligible for pension under section 521 of this title, or (ii) a veteran who is determined, under regulations prescribed by the Administrator, to be unable to defray the expenses of the travel for which payment under this section is claimed.

“(D) A veteran whose travel to a Veterans' Administration facility was incident to a scheduled compensation and pension examination.

“(2)(A) Except as provided in subparagraph (B), (C), or (D) of this paragraph, the Administrator, in making a payment under this section to or for a person described in subparagraphs (A), (B), or (C) of paragraph (1) of this subsection for travel for examination, treatment, or care, shall deduct from the amount otherwise payable an amount equal to $3.75 for one-way each trip.

"(B) In the case of a person who is determined by the Administrator to be a person who is required to make six or more one-way trips for needed examination, treatment, or care during the remainder of the calendar month in which the determination is made or during any subsequent calendar month during the one-year period following the last day of the month in which the determination is made, the amount deducted by the Administrator pursuant to subparagraph (A) of this paragraph from payments for trips made to or from such facility during any such month shall not, except as provided in subparagraph (D) of this paragraph, exceed $22.50.

"(C) No deduction shall be made pursuant to subparagraph (A) of this paragraph in the case of a person whose travel to or from a Veterans' Administration facility was required to be performed by a special mode of travel and such travel (i) was authorized by the Administrator before such travel was commenced, or (ii) was in connection with a medical emergency of such a nature that the delay incident to obtaining authorization under clause (i) of this subparagraph would have been hazardous to the person's life or health. In the case of such travel, if the Administrator determines that providing payment prior to determining the eligibility of such person is in the best interest of furnishing care and services, the Administrator may so provide payment to the provider of the transportation subject to subsequently recovering from such person the amount of the payment if such person is determined to have been ineligible for payment for such travel.

"(D) Whenever the Administrator increases or decreases the rates of allowances or reimbursement to be paid under this section, the Administrator shall, effective on the date on which such increase or decrease takes effect, adjust proportionately the dollar amounts specified in subparagraphs (A) and (B) of this paragraph as such amounts may have been increased or decreased pursuant to this subparagraph prior to such date.";

(3) in paragraph (4) of subsection (f) (as redesignated by clause (1))—

(A) by inserting "or adjusting amounts" after "rates" the first place it appears; and

(B) by inserting "and amounts" after "rates" the third place it appears; and

(4) by adding at the end the following new subsections:

"(g)(1) Whenever the Administrator exercises with respect to any fiscal year the authority to make payments under this section, the Administrator shall, not later than the fifteenth day after the date on which the Administrator so exercises such authority or the first day of such year, whichever is the later, make an allocation to each Veterans' Administration medical facility sufficient to enable the head of such facility to make such payments during the portion of the year beginning on the first day as to which the authority is exercised and ending on the last day of such year to persons eligible for such payments under subsection (b) of this section.

"(2)(A) In any fiscal year in which funds are allocated pursuant to paragraph (1) of this subsection, the head of each such facility, unless granted a waiver under subparagraph (B) of this paragraph and regulations which the Administrator shall prescribe thereunder, shall utilize such funds solely for the purpose of making payments under this section.

"(B)(i) In any case in which the head of such a facility demonstrates to the Chief Medical Director that, on April 12, 1987, such facility was making payments under this section at an annual expenditure level less than the annual expenditure level would have been if such payments were being made to all eligible persons in the maximum amounts then authorized under this section, the Chief Medical Director shall waive the provisions of subsection (b) of this section and authorize payments to be made at any such prior level or at any higher level, proposed by such facility head, that is less than the level that would otherwise be provided for under this section.

"(ii) In any other case in which the head of such facility proposes to make payments under this section at an annual expenditure level less than the level that would otherwise be provided for under at this section, if the Chief Medical Director determines that making payments at such lesser level, or at any higher level that is less than the level that would otherwise be provided for under such subsection, would be in the best interest of furnishing care and services to eligible veterans at such facility, the Chief Medical Director may waive the provisions of subsection (b) of this section and authorize payments to be made at the level specified in the Chief Medical Director's determination.

"(C) Any funds which are allocated to a facility pursuant to paragraph (1) of this section for the purpose of payments under this section but which, pursuant to a waiver granted under subparagraph (B) of this paragraph, are not expended for such purpose shall be available to the head of such facility to be expended for direct patient-care service.

"(h)(1) The Administrator, in consultation and coordination with the Secretary of Transportation and appropriate representatives of veterans' service organizations, shall take all appropriate steps to facilitate the establishment and maintenance of a program under which such organizations, or individuals who are volunteering their services to the Veterans' Administration, would take responsibility for the transportation, without reimbursement from the Veterans' Administration, to Veterans' Administration facilities of veterans, primarily those residing in areas which are geographically accessible to such facilities, who seek services or benefits from the Veterans' Administration under chapter 17 or other provisions of this title.

"(2) Not later than 6 months after the date of the enactment of this subsection, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the implementation of this subsection.".

TITLE II—QUALITY ASSURANCE PROGRAM

SEC. 201. ESTABLISHMENT OF OFFICE OF MEDICAL INSPECTOR GENERAL.

(a) In General.—Chapter 73 is amended by inserting after section 4103 the following new section:

"§ 4103A. Office of Medical Inspector General

"(a) There is established in the Office of the Chief Medical Director an Office of Medical Inspector General.

"(b) The Office of the Medical Inspector General shall consist of the following:

"(1) The Medical Inspector General who (A) shall be the head of the Office of Medical Inspector General, (B) shall be directly responsible to the Chief Medical Director for such functions as may be assigned to the Medical Inspector General in regulations prescribed by the Chief Medical Director consistent with the provisions of this section, and (C) shall be a qualified doctor of medicine appointed by the Administrator upon recommendation of the Chief Medical Director.

"(2) Not less than five Assistant Medical Inspectors General who shall be qualified doctors of medicine, doctors of dental surgery or dental medicine, or registered nurses and who shall be employed on a full-time basis in the Veterans' Administration.

"(3) Not less than two registered nurses (including any who are Assistant Medical Inspectors General) who are employed on a full-time basis in the Veterans' Administration.

"(4) Not less than one qualified doctor of dental surgery or dental medicine (who may be an Assistant Medical Inspector General) who is employed on a full-time basis in the Veterans' Administration.

"(5) Not less than five support personnel, who are employed on a full-time basis in the Veterans' Administration.

"(c) The Medical Inspector General shall be appointed for a term of 4 years, with reappointment permissible for successive like periods. The Medical Inspector General shall be subject to removal by the Administrator only for reasonable cause upon the recommendation of the Chief Medical Director.

"(d)(1) The Medical Inspector General shall monitor, review, and investigate any adverse incident which is experienced by a patient during the course of the patient's care in a Veterans' Administration health-care facility, including any incident that would not normally be considered a natural consequence of the patient's disease process or illness and any incident that would carry a recognized need for medical intervention.

"(2) The Medical Inspector General shall also conduct such reviews and investigations as the Medical Inspector General considers necessary to identify problems in the provision of health care to veterans and, when problems are detected, shall propose to the Chief Medical Director such corrective measures as the Medical Inspector General considers necessary or appropriate.

"(3) The Medical Inspector General shall conduct such other studies, reviews, and investigations relating to the quality of health care provided to veterans as the Administrator or the Chief Medical Director may assign to the Medical Inspector General.

"(4) Subject to paragraph (3) of this subsection, the Medical Inspector General shall have sole discretion in determining whether to investigate any incident involving patient care or to study or review any problem in the provision of health care to veterans.

"(e) In conducting an investigation of any incident involving the care of a patient or any study or review of any problem in the provision of health care to veterans, the Medical Inspector General shall assign to the investigation, study, or review at least one health-care professional from the Office of the Medical Inspector General.

"(f) The Medical Inspector General shall submit to the Administrator, the Chief Medical Director, and the Committees on Veterans' Affairs of the Senate and the House of Representatives a report not later than February 1 of each year, on the activities of the Office of the Medical Inspector General under this section during the preceding fiscal year. The Medical Inspector General shall include in each such report—

"(1) a description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department of Medicine and Surgery disclosed by such activities during the preceding fiscal year;

"(2) a description of (A) the recommendations for corrective action and of any recommendations for disciplinary action made by the Office during the preceding fiscal year with respect to significant problems, abuses, or deficiencies identified pursuant to clause (1) of this subsection, and (B) the action taken as of the end of such fiscal year on each such recommendation, including any such recommendations on which action had not been completed prior to the end of such fiscal year;

"(3) a specification of (A) which activities of the Office were carried out pursuant to an assignment by the Administrator or the Chief Medical Director, and (B) which activities of the Office were carried out on the initiative of the Medical Inspector General;

"(4) an identification of each significant recommendation for corrective or disciplinary action described in the report or in previous annual reports under this subsection on which action has not been completed;

"(5) a summary of any matters referred to prosecutorial authorities and the prosecutions and convictions which have resulted; and

"(6) a summary of each incident in which information or assistance requested by the Medical Inspector General from the Department of Medicine and Surgery during the preceding fiscal year has been, in the judgment of the Medical Inspector General, unreasonably refused or not provided.

"(g) The Medical Inspector General shall be an ex officio, nonvoting member of all policymaking bodies within the central office of the Department of Medicine and Surgery that are concerned with the quality of health care provided in Veterans' Administration facilities or that are concerned with quality assurance in the provision of such care. The Medical Inspector General shall not, however, have any direct responsibility for quality assurance activities, including patient risk management and the reporting of patient injuries under quality assurance procedures.

"(h)(1) The Administrator shall transfer to the Office of the Medical Inspector General each fiscal year, out of any funds available to the Veterans' Administration for such fiscal year (other than funds available for the operation of the central office of the Department of Medicine and Surgery), such amounts as may be necessary, as determined by the Chief Medical Director, to support five full-time medical doctors and five full-time support personnel in the Office of the Medical Inspector General.

"(2) The positions of five full-time medical doctors and five full-time support personnel in the Office of Medical Inspector General shall be counted against the number of full-time employees authorized by the Office of Management and Budget for the program, function, or activity for which the funds transferred pursuant to paragraph (1) of this subsection would be available except for the transfer of such funds. In the event that the Administrator transfers funds from more than one program, function, or activity, the ten full-time positions shall be counted against the number of such positions authorized by the Office of Management and Budget for each such program, function, or activity in proportion to the amount of funds transferred therefrom."

(b) Conforming Amendment.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 4103 the following:

"4103A. Office of Medical Inspector General.".

SEC. 202. ASSISTANT CHIEF MEDICAL DIRECTOR FOR QUALITY ASSURANCE.

Section 4103(a)(4) is amended by adding at the end the following new sentence: "One Assistant Chief Medical Director shall be a qualified physician trained in, or having suitable extensive experience in, health-care quality assurance and risk management who shall be responsible to the Chief Medical Director for carrying out the responsibilties assigned to the Chief Medical Director in subchapter V of this chapter and such related responsibilities as are assigned to the Assistant Chief Medical Director by the Chief Medical Director.".

SEC. 203. IMPLEMENTATION OF THE HEALTH CARE QUALITY ASSURANCE PROGRAM.

Section 4151 is amended by adding at the end the following:

"(f) The Chief Medical Director shall take such action as may be necessary to ensure that all personnel of the Department of Medicine and Surgery—

"(1) are given an explanation periodically of their responsibilities for the quality assurance activities of such department; and

"(2) are advised that any failure to comply with quality assurance procedures prescribed in regulations or in procedural publications issued by the Department of Medicine and Surgery, including any failure to report any incident as required under such procedures, will result in appropriate disciplinary action.".

SEC. 204. ESTABLISHMENT OF THE VETERANS' ADMINISTRATION ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE QUALITY ASSURANCE REVIEW.

(a) IN GENERAL.—(1) Chapter 3 is amended by adding at the end the following new subchapter:

"SUBCHAPTER V—OTHER VETERANS' ADMINISTRATION OFFICES

"§ 250. Assistant Inspector General for Health Care Quality Assurance Review

"(a) There is established in the Veterans' Administration Office of the Inspector General, in addition to the positions of Assistant Inspector General of the Veterans' Administration provided under section 3(d) of the Inspector General Act of 1978 (5 U.S.C. App. 3), the position of Assistant Inspector General for Health Care Quality Assurance Review.

"(b) The Administrator shall make available to the Office of the Inspector General sufficient resources to provide for an Assistant Inspector General for Health Care Quality Assurance Review and the personnel required by subsection (d) of this section and to enable such Assistant Inspector General and personnel to perform the duties of such Assistant Inspector General.

"(c) The Assistant Inspector General for Health Care Quality Assurance Review shall be a qualified doctor of medicine appointed by the Inspector General of the Veterans' Administration.

"(d) The staff of the Assistant Inspector General for Health Care Quality Assurance Review shall include the following:

"(1) Not less than two qualified doctors of medicine.

"(2) Not less than one qualified doctor of dental surgery or dental medicine.

"(3) Not less than one qualified registered nurse.

"(4) Not less than one attorney who has expertise in health-care law.

"(5) Not less than one individual who has expertise in health-care quality assurance and risk management.

"(6) Not less than one individual who has expertise in health-care administration.

"(7) A sufficient number of support and additional personnel, but not less than the equivalent of five full-time personnel, to enable the Assistant Inspector General for Health Care Quality Assurance Review to perform the duties of such Assistant Inspector General.

"(e) The Assistant Inspector General for Health Care Quality Assurance Review, in addition to performing (with respect to activities of the Department of Medicine and Surgery) such other functions and duties prescribed for the Inspector General of the Veterans' Administration in the Inspector General Act of 1978 (5 U.S.C. App. 3) as may be directed by the Inspector General, shall—

"(1) monitor, including through reviews of Veterans' Administration health-care facilities, the establishment and implementation of the health-care quality assurance and risk management programs of the Department of Medicine and Surgery;

"(2) monitor the activities of the Medical Inspector General of the Department of Medicine and Surgery;

"(3) recommend that the Medical Inspector General of the Department of Medicine and Surgery conduct such investigations as the Assistant Inspector General for Health Care Quality Assurance Review considers appropriate;

"(4) coordinate the activities of the Assistant Inspector General with the activities of the Medical Inspector General of the Department of Medicine and Surgery;

"(5) review any investigation conducted by the Medical Inspector General of the Department of Medicine and Surgery of any adverse incident or incidents occurring during the course of furnishing health-care services in a Veterans' Administration facility or facilities and make such recommendations for additional action to such Medical Inspector General as the Assistant Inspector General considers appropriate;

"(6) monitor and analyze the collection and analysis of quality assurance and risk management information by the Department of Medicine and Surgery (including information relating to medical malpractice claims), review such quality assurance and risk management information in order to identify data that is not collected and should be collected, and monitor the analysis by the Department of Medicine and Surgery of trends in the provision of health-care services by such Department;

"(7) make to the Inspector General such recommendations for corrective action on health-care matters as the Assistant Inspector General considers appropriate; and

"(8) monitor the implementation of recommendations for corrective action made to the Administrator by the Inspector General on health-care matters.

"(f) The Inspector General of the Veterans' Administration, in addition to preparing and submitting the reports required by the Inspector General Act of 1978 (5 U.S.C. App. 3), shall submit to the Administrator and the Committee on Veterans' Affairs of the Senate and the House of Representatives, not later than February 1 of each year, a report containing—

"(1) a discussion of the activities undertaken by the Assistant Inspector General for Health Care Quality Assurance Review during the fiscal year preceding the fiscal year in which the report is submitted, including—

"(A) the findings and conclusions resulting from such activities;

"(B) the recommendations made (on the basis of such activities) by the Inspector General to the Administrator for corrective action in the activities of the Department of Medicine and Surgery; and

"(C) any corrective actions taken with respect to those recommendations; and

"(2) a discussion of the activities undertaken by the Assistant Inspector General for Health Care Quality Assurance Review to monitor the activities of the Medical Inspector General of the Department of Medicine and Surgery during the fiscal year preceding the fiscal year in which the report is submitted, including—

"(A) the findings of the Inspector General of the Veterans' Administration and the Assistant Inspector General on the activities of the Medical Inspector General during such preceding fiscal year;

"(B) the recommendations, if any, made by the Inspector General of the Veterans' Administration to the Chief Medical Director or the Administrator on the basis of such monitoring activities, including any recommendations for remedial or disciplinary actions as a result of such activities; and

"(C) an assessment of the extent to which the Inspector General has been effective during such preceding fiscal year in bringing about such recommended remedial and disciplinary actions.

"(g) The rate of pay for the position of Assistant Inspector General for Health Care Quality Assurance Review shall be the same rate of pay established for the positions of the other Assistant Inspectors General of the Veterans' Administration.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following:

"SUBCHAPTER V—OTHER VETERANS' ADMINISTRATION OFFICES

"250. Assistant Inspector General for Health Care Quality Assurance Review.".

(b) Resources for Monitoring Quality Assurance Program.—Section 4151(e)(2) is amended by inserting "to the Assistant Inspector General for Health Care Quality Assurance Review" after "qualifications)".

TITLE III—VIETNAM VETERANS' READJUSTMENT COUNSELING PROGRAMS

SEC. 301. READJUSTMENT COUNSELING PROGRAM IMPROVEMENTS.

(a) Section 612A is amended—

(1) in subsection (a)—

(A) by inserting "(1)" before "Upon";

(B) by amending the first sentence of paragraph (1) (as redesignated by clause (A) of this section) to read as follows:

"Upon the request of—

"(A) any veteran who served on active duty during the Vietnam era, or

"(B) any veteran who served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in paragraph (3) of this subsection) occurred in such area,

the Administrator shall furnish counseling to assist such veteran in readjusting to civilian life."; and

(C) by adding at the end the following new paragraphs:

"(2) Upon the request of (A) any veteran who served on active duty during World War II or the Korean conflict, or (B) any person who is serving on active duty and who served on active duty during either of the periods described in clause (A) or (B) of the first sentence of paragraph (1) of this subsection, the Administrator may furnish counseling to such veteran or person in overcoming any psychological problems associated with such veteran's or person's service during such period. In furnishing counseling under clause (A) of the first sentence of this paragraph, the Administrator shall place particular emphasis on the needs of those who engaged in combat with the enemy. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran or person has mental or psychological problems associated with such veteran's or person's active military, naval, or air service.

"(3) For the purposes of subparagraph (1)(B) of this subsection, the term 'hostilities' means a situation in which members of the Armed Forces were, as determined by the Administrator in consultation with the Secretary of Defense, subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in battle with the enemy during a period of war.";

(2) in subsection (d)—

(A) by inserting "(1)" before "The"; and

(B) by adding at the end the following new paragraph:

"(2)(A) Any individual who has satisfactorily completed 2 years of substantially continuous employment in the program established to carry out this section under a time-limited appointment and who is so employed on the ninetieth day after the date of the enactment of this paragraph shall be converted by the Administrator to career-conditional or career employment. Such conversion shall be accomplished not later than (i) 30 days after the date on which such 2-year period has expired, or (ii) 120 days after the date of the enactment of this paragraph, whichever is the later. An employee converted under this paragraph shall automatically acquire a competitive status.

"(B) Not later than 15 days after an individual becomes entitled to conversion under subparagraph (A) of this paragraph, the Administrator shall notify such individual of such entitlement and the timetable for such employee's conversion.";

(3) in subsection (g)—

(A) by amending paragraph (1) to read as follows:

"(1)(A) No Vet Center in existence on July 1, 1987, may be closed or relocated to another location unless the Chief Medical Director—

"(i) determines, in accordance with subparagraph (B) of this paragraph and pursuant to regulations prescribed by the Chief Medical Director, that such closure or relocation will not result in any diminution in the continuing availability and effective furnishing of readjustment counseling services to persons entitled to and needing such services in the geographic area served by such Vet Center, and so certifies in the notification described in clause (iii) of this subparagraph;

"(ii) in the case of such a relocation, certifies in such notification that the requirements of subparagraph (C) of this paragraph will be met; and

"(iii) provides to the Committees on Veterans' Affairs of the Senate and the House of Representatives at least 60 days prior to any such closure or relocation a notification thereof, including a description of the results of the consideration given to the factors specified in subparagraph (B) of this paragraph.

"(B) In making a determination under clause (i) of subparagraph (A) of this paragraph, the Chief Medical Director shall give full consideration to—

"(i) the distribution of Vietnam-era veterans in the geographical area served by the existing Vet Center and the relationships between the location of such Vet Center and the general Veterans' Administration facility and such distribution;

"(ii) the distance between the existing Vet Center and the general Veterans' Administration facility;

"(iii) the acceptability of the proposed closure or relocation to (I) the staff of both the existing Vet Center and the general Veterans' Administration facility, (II) representatives of veterans' service organizations located in the geographic area served by the existing Vet Center, and (III) individual veterans who are being furnished services at the existing Vet Center;

"(iv) the availability of other entities, such as State, local, or private outreach facilities, which provide assistance to Vietnam-era veterans in the area served by the existing Vet Center;

"(v) the availability of transportation to, and parking at, the existing Vet Center and the general Veterans' Administration facility;

"(vi) the availability, cost, and suitability of the space at the general Veterans' Administration facility, including the opportunity to establish a direct entry into the area where readjustment counseling services would be furnished and the suitability of the environment where such services would be furnished;

"(vii) a comparison of the recurring non-personnel costs of providing readjustment counseling to the same estimated number of veterans at the existing Vet Center and the general Veterans' Administration facility;

"(viii) the impact of the proposed closure or relocation on the program at the existing Vet Center pursuant to which eligible veterans are furnished readjustment counseling services by private facilities under a contract with the Veterans' Administration; and

"(ix) the workload trends over the prior 2 fiscal years at the existing Vet Center; and

"(x) such other factors, specified in the regulations prescribed under subparagraph (A)(i) of this paragraph, as the Chief Medical Director determines are relevant to making the determination described in such subparagraph (A)(i).

"(C)(i) Except as provided in division (ii) of this subparagraph, in the case of a relocation of a Vet Center to a general Veterans' Administration facility, not less than the average annual budget and personnel ceiling provided to such Vet Center in each of the 3 fiscal years prior to such relocation (calculated on an annualized basis for any year in which a Vet Center was not operational for an entire year) will remain available to furnish readjustment counseling services for 2 full fiscal years following such relocation.

"(ii) In the event that the Chief Medical Director determines at the end of the first full fiscal year following such relocation that the demand for services at the relocated Vet Center's current location, when compared with the demand for services at such Vet Center's prior location, does not then justify the budget and personnel ceiling levels described in division (i) of this subparagraph, the Chief Medical Director may, as an exception to such division, reduce such levels to such levels needed to meet such demand and the estimated future demand for such services if (I) the Chief Medical Director determines that relocation of the Vet Center to a location away from the general Veterans' Administration facility is highly unlikely to result in a demand sufficient to justify the levels initially provided, and (II) the Chief Medical Director promptly notifies the Committees on Veterans' Affairs of the Senate and the House of Representatives of such determinations and the bases therefor.

"(D)(i)(I) Any proposed closure or relocation during any fiscal year after fiscal year 1988 of more than 10 percent of the Vet Centers in existence on July 1, 1987, shall be deemed to be an administrative reorganization for the purposes of section 210(b)(2) of this title.

"(II) Not more than 5 percent of the Vet Centers (including relocated Vet Centers) in existence on July 1, 1987, may be closed or relocated to a general Veterans' Administration facility prior to October 1, 1988.

"(ii)(I) Except as provided in subdivision (II) of this division, in the event of a proposed administrative reorganization as described in division (i) of this subparagraph, the Administrator, at the time specified in subparagraph (A) of such section 210(b)(2), shall submit, in lieu of a report containing a detailed plan and justification, a notification as described in subparagraph (A)(iii) of this paragraph including information as to each Vet Center or relocated Vet Center that is proposed to be closed or relocated and a justification of such proposed administrative reorganization in light of the contents of the report required to be submitted by paragraph (2) of this subsection, particularly the contents of such report in response to the requirement in the second sentence of subparagraph (A) of such paragraph.

"(II) In the event of a proposed administrative reorganization as described in division (i) of this subparagraph which is proposed to take effect in fiscal year 1989, the

Administrator may delay submitting the notification described in subdivision (I) of this division until the date on which the report required by subsection (g)(2) of this section is submitted or to April 1, 1988, whichever is the earlier.

"(E) For the purposes of this paragraph—

"(i) the term 'general Veterans' Administration facility' means a Veterans' Administration facility which is not a Vet Center and at which readjustment counseling would be furnished in a particular geographic area upon the closure or relocation of a Vet Center; and

"(ii) the term 'relocated Vet Center' means a Vet Center that has been relocation to a general Veterans' Administration facility.";

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) by striking out "April 1, 1987" and inserting in lieu thereof "April 1, 1988"; and

(II) by striking out "(or" and all that follows through "available)";

(ii) in subparagraph (B)—

(I) by striking out in clause (i) "a program" and all that follows through "health-care facilities" and inserting in lieu thereof "Vet Centers"; and

(II) in clause (ii) by striking out "paragraph (1) of"; and

(C) by striking out paragraphs (3) and (4);

(4) by redesignating subsection (h) as subsection (i);

(5) by inserting after subsection (g), the following new subsection:

"(h)(1) The Administrator may provide to eligible veterans at Vet Centers, in addition to furnishing readjustment counseling services under this section, other services (including counseling with respect to, and assistance in applying for, all benefits and services under laws administered by the Veterans' Administration for which such veterans may be eligible) that the Administrator is authorized to furnish such veterans.

"(2) The Administrator may assign such personnel and other resources as are necessary to provide such additional services under this subsection and are otherwise available to the Administrator for such purpose."; and

(6) by adding at the end the following new subsection (j):

"(j) For the purposes of this section:

"(1) The term 'Vet Centers' mean facilities (including Centers) which are operated by the Veterans' Administration for the provision of services under this section and which (except in the cases of 'relocated Vet Centers' (as that term is defined in subsection (g)(1) of this section)) are situated apart from Veterans' Administration general health-care facilities.

"(2) The term 'Veterans' Administration general health-care facilities' means health-care facilities which are operated by the Veterans' Administration for the furnishing of health-care services under this chapter, not limited to services provided through the programs established under this section.".

(b) Not later than 150 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of the amendment made by subsection (a)(2)(B). Such report shall include information on the number of employees employed under a time-limited appointment on the date 90 days after such date of enactment, the number, assignment, and duty station of those converted to career-conditional or career employment by the date 120 days after such enactment date, and the plans and timetable for accomplishing the conversion of other such employees.

SEC. 302. POSTPONEMENT OF REPORT DUE DATE.

Section 102(b) of the Veterans' Health Care Amendments of 1983 (Public Law 98–160; 97 Stat. 994) is amended by striking out "October 1, 1986" and inserting in lieu thereof "October 1, 1987".

SEC. 303. PROHIBITION ON DELEGATION OF AUTHORITY.

The functions and authorities assigned to the Chief Medical Director of the Veterans' Administration by any provision of this title or any amendment made by this title may not be delegated to or exercised by any other official.

Amend the title so as to read:

To amend title 38, United States Code, to restore beneficiary travel payments to certain individuals in connection with travel to and from Veterans' Administration facilities, to establish the Office of Medical Inspector General, and the position of

Assistant Chief Medical Director for Quality Assurance, in the Office of the Chief Medical Director of the Veterans' Administration and the position of Assistant Inspector General for Health Care Quality Assurance Review in the Office of the Inspector General of the Veterans' Administration, and to eliminate the requirement for a transition under which community-based Vet Centers would be moved to Veterans' Administration medical facilities and provide standards and procedures for any closure or relocations of Vet Centers; and for other purposes.

INTRODUCTION

S. 1464 was introduced on July 1, 1987, by the Chairman of the Committee, Senator Alan Cranston, and cosponsored by the Ranking Minority Member, Frank H. Murkowski, Committee Members Spark M. Matsunaga, Dennis DeConcini, John D. Rockefeller IV, Bob Graham, and Robert T. Stafford, and Senators Daniel P. Moynihan, Howell T. Heflin, Jeff Bingaman, Christopher J. Dodd, Thomas A. Daschle, Terry Sanford, Lawton Chiles, William S. Cohen, Daniel J. Evans, and Charles E. Grassley. Joining later as cosponsors were Committee Members Strom Thurmond and Arlen Specter and Senators William V. Roth, Jr., Chic Hecht, Thad Cochran, Max Baucus, Richard C. Shelby, Quentin N. Burdick, Bill Bradley, David Pryor, Brock Adams, Patrick J. Leahy, Albert Gore, Jr., Paul S. Trible, Jr., John F. Kerry, John Melcher, Daniel D. Inouye, and Paul Simon. As introduced, S. 1464 would have provided for the payment of beneficiary travel reimbursements—payments generally made to certain veterans to defray the expenses of their travel to Veterans' Administration health-care facilities—to certain service-connected disabled veterans and low-income veterans, and would have provided for a deductible of $3.75 per one-way trip from such reimbursements, except that a maximum total of $22.50 in deductibles would have been required of certain frequent users of VA care, and no deductible would have been required in connection with special-mode or emergency transportation.

On June 26, 1987, S. 1443 and S. 1444 were introduced as complementary measures. S. 1443, introduced by Chairman Cranston and cosponsored by Ranking Minority Membert Murkowski and Committee Members Matsunaga, DeConcini, Graham, and Simpson, would have provided for the upgrading within the VA's Department of Medicine and Surgery (DM&S) of the medical investigation, quality-assurance, and risk-management programs and operations by establishing an autonomous Office of the Medical Inspector General (MIG), with specified staffing and direct accountability to the Chief Medical Director, which would be charged with investigating reports of inadequate quality of care, and by establishing an Assistant Chief Medical Director for Quality Assurance. S. 1444, introduced by Senator Murkowski and cosponsored by Senator Cranston and Committee Members Specter, Simpson, Thurmond, Matsunaga, DeConcini, and Graham, would have upgraded the monitoring by the VA's independent Inspector General of DM&S's quality assurance, risk management, and inspection activities by establishing a new Assistant Inspector General for Health Care Quality Assurance Review with a specified minimum staffing level and a statutory functional statement.

On July 15, 1987, Chairman Cranston introduced S. 1501 with the cosponsorship of Committee members Senators Matsunaga, DeConcini, MItchell, Rockefeller and Graham, and Senators Dodd, Kerry, Gore, Harkin, and Daschle. Joining later as cosponsors were Senators Cohen, Simon, Pell, and Bingaman. As introduced, S. 1501 would have granted readjustment counseling entitlement to certain additional categories of veterans and active-duty personnel, would have eliminated the requirement in current law that the Administrator of Veterans' Affairs carry out a transition under which community-based Vet Centers would be moved to general VA facilities, and would have provided standards and procedures governing any closure or relocation of existing Vet Centers.

On July 17, 1987, Chairman Cranston submitted Amendment No. 610 to S. 1501. Amendment No. 610 would have made a technical correction in the description of two groups of individuals who would be given entitlement to readjustment counseling by S. 1501 so as to clarify that individuals in those two groups are active-duty personnel.

Due to the urgency accompanying these issues, these measures were not the subject of specific Committee hearings. However, testimony was received at the Committee's February 18 and May 21 hearings in regards to a proposed one-year extension of the readjustment counseling program and provisions relating to eligibility for such services. Also, certain comments were received in the form of letters and informal communications from the Veterans' Administration, the Department of Defense, veterans' service organizations, and others interested in the various issues. After carefully reviewing this testimony and these comments, the Committee met in open session on July 31, 1987, and voted unanimously (after an amendment to substitute for the text of title III failed in a 5–6 vote) to report favorably S. 1464 with an amendment in the nature of a substitute, which incorporated provisions derived from S. 1464 as introduced as title I, S. 1443 and S. 1444 as title II, and S. 1501 and Amendment No. 610 as title III.

SUMMARY OF S. 1464 AS REPORTED

S. 1464 as reported (hereinafter referred to as the "Committee bill") has three titles: Title I, Beneficiary Travel Reimbursement; Title II, Quality Assurance Program; and Title III, Readjustment Counseling Program. Following is a summary of the provisions of these titles.

TITLE I—BENEFICIARY TRAVEL PROGRAM

This title includes provisions which would establish a statutory framework pursuant to which beneficiary travel reimbursement would be made to certain veterans in connection with their travel to VA facilities. These provisions would:

1. Require the Administrator of Veterans' Affairs, if the Administrator makes any beneficiary travel payments in any fiscal year, to provide beneficiary travel reimbursements during that year to those who were eligible for such payments prior to the issuance on April 13, 1987, of VA regulations restricting eligibility—namely, persons receiving benefits for or in connection with a service-connected disability, veterans with annual incomes not more than pension rates, and those who are otherwise unable to defray the cost of transportation.

2. Apply a $3.75 one-way deductible in connection with any such travel except for veterans travelling by special modes of transportataion or to take compensation and pension examinations.

3. Limit the veterans' cost as a result of the deductible to a maximum $22.50 per month for those who, prior to such travel, are approved by the VA as being required to make frequent trips to the VA.

4. Require the Administrator, with respect to any fiscal year in which the Administrator makes any beneficiary travel payments, to allocate to each VA medical facility funds sufficient to make such payments in accordance with the provisions described in items 1 to 3, above.

5. Provide to VA facility directors, subject to the approval of the Chief Medical Director (CMD), flexibility to reduce or eliminate beneficiary travel reimbursements under certain circumstances and thus make certain beneficiary travel funding allocations available for direct-care purposes.

6. Require the Administrator to promote the establishment and maintenance of transportation networks, in conjunction with veterans' service organizations and the Secretary of Transportation, to promote local transportation for veterans to VA facilities.

TITLE II—QUALITY ASSURANCE PROGRAM

This title includes provisions which would establish an expanded and autonomous Office of the Medical Inspector General and strengthen the activities of the Office of the Inspector General for the purpose of ensuring a high quality of health care within VA facilities. Those provisions would:

1. Establish an expanded and autonomous Office of the Medical Inspector General (MIG), directly accountable to the CMD, with specified support positions and funding and responsibility for investigating reports of inadequate quality of care and other matters relating to quality of care as determined by the MIG or CMD.

2. Establish the position of Assistant Chief Medical Director for Quality Assurance directly accountable to the CMD and with responsibility for the VA's statutorily-mandated quality-assurance program.

3. Require the CMD to issue regulations prescribing appropriate disciplinary action when employees fail to comply with reporting requirements relating to the quality-assurance program.

4. Establish within the VA's Office of Inspector General (IG) an Assistant Inspector General for Health Care Quality Review, and support positions, responsible for comprehensive monitoring of the functioning of the MIG's operation as well as of the DM&S quality assurance and risk management programs.

5. Require the MIG and IG to submit annual reports on their activities, findings, and recommendations for the preceding fiscal year to the CMD, Administrator, and House and Senate Committees on Veterans' Affairs.

TITLE III—VIETNAM VETERANS' READJUSTMENT COUNSELING PROGRAMS

This title includes provisions which would, among other things, repeal the requirement in current law that the Administrator of

Veterans' Affairs must carry out a transition under which a majority of community-based Vet Centers would be moved to general VA facilities and provide standards and procedures governing any closure or relocation of existing Vet Centers. These provisions would:

1. Eliminate the statutory mandate for the transition of the Vietnam-era veteran readjustment counseling program from one conducted primarily through Vet Centers in community locations to one conducted primarily through VA medical facilities.
2. Replace the statutory mandate with provisions permitting the closure of a Vet Center or the relocation of a Vet Center in a general VA facility, such as a VA medical center, only upon case-by-case determinations by the Chief Medical Director after taking into account certain criteria relating to ensuring the continued availability and effective provision of readjustment counseling services.
3. Require that 60 days' advance notification, including the results of consideration of the specified criteria, be submitted to the Veterans' Affairs Committees before any such relocations are made.
4. Protect for 2 years the budget and personnel ceiling for any Vet Center relocated to a VA medical facility but would allow the CMD to reduce the budget and ceiling after one year on the basis of a determination of a reduction in workload.
5. Provide for the closure or relocation in any fiscal year of 10 percent or more of the Vet Centers in existence on July 1, 1987, to be deemed to be an "administrative reorganization" for the purposes of existing reorganization requirements in section 210(b) of title 38, thereby allowing such a reorganization to proceed for a fiscal year only if, at the time of the President's budget submission for that fiscal year—approximately 8 months before the first day thereof—Congress is given notification of the reorganization and certain information relating to the bases for it.
6. Extend entitlement for readjustment counseling to veterans who have served in hostilities after May 7, 1975, the end of the Vietnam era.
7. Extend eligibility for readjustment counseling to active-duty personnel who served during the Vietnam era or in hostilities after May 7, 1975, the end of the Vietnam era, and to World War II and Korean conflict veterans, with particular emphasis in the furnishing of counseling on the needs of those who served in combat.
8. Explicitly authorize the provision of appropriate Department of Veterans' Benefits and health services at Vet Centers.
9. Require that, 90 days after the date of enactment, all Vet Center personnel who have served satisfactorily and substantially continuously for 2 years be converted to career positions.

Discussion

TITLE I—BENEFICIARY TRAVEL PROGRAM

Title I of the Committee bill, which is derived from S. 1464 as introduced, would restore VA beneficiary travel reimbursements. These benefits were significantly reduced by amendments to the governing regulations (section 17.100 of title 38, Code of Federal Regulations, which was modified by amendments published on pages 7575–77 of the March 12, 1987, Federal Register), which, effective April 13, 1987, eliminated VA payments for the non-emergency travel by non-special modes of transportation of veteran-patients who live within a 100-mile radius of the facility at which they seek health care. However, in order to limit the added costs, a $3.75 one-way deductible would apply except for veterans otherwise eligible for beneficiary travel reimbursement travelling by special modes of transportation or any veteran travelling to receive a compensation and pension examination. In order to limit veteran costs associated with travel to and from VA facilities, there would be a $22.50-per-month cap on the deductible for those veterans who are pre-approved as needing to travel on a frequent basis. The Committee bill would also clarify the VA's authority to pay a provider of transportation by special mode before making a determination as to the patient's eligibility for beneficiary travel benefits, subject to later billing any patient found ineligible for payment for the travel. Subject to Central Office approval, VA facility directors would have flexibility to reduce or eliminate beneficiary travel reimbursements under certain circumstances when it is determined, after consultation with local representatives of veterans, that such action would be most beneficial to meeting the health-care needs of veterans in the area served. Finally, the Administrator would be directed to promote through the agency's Voluntary Service the establishment and maintenance of transportation networks, in conjunction with veterans' service organizations and the Secretary of Transportation, to promote local transportation for veterans to VA facilities.

Background

Section 111 of title 38, United States Code, in conjunction with certain other title 38 authorities, provides a discretionary program for the payment of the necessary travel expenses of certain VA beneficiaries. Section 111 specifies that the Administrator may provide reimbursement or allowances to certain veterans, dependents, and survivors travelling in connection with vocational rehabilitation or educational counseling or for the purpose of examination, treatment, or care as authorized under title 38 or other law. Those eligible for payment include (1) veterans and dependents or survivors receiving benefits in connection with a service-connected disability, (2) veterans receiving pensions under section 521 of title 38, (3) persons whose annual incomes do not exceed the maximum annual rate of pension that would be applicable under section 521 if they were otherwise eligible for pension, and (4) persons who have been determined, pursuant to regulations promulgated by the Administrator, to be unable to defray the expenses of travel. In 1983, the VA published regulations, codified in section 17.100 of title 38 of the Code of Federal Regulations and modified by the April 13 amendments, which provide for paying travel expenses based on inability to defray only when the individual "can present clear and convincing evidence, in a form prescribed by the Administrator, to show the inability to defray the cost of transportation" or "when medically-indicated ambulance transportation is claimed and an administrative determination is made regarding the claimant's ability to bear the cost of such transportation."

On February 7, 1985, in response to a December 2, 1983, request from Senator Simpson, then Chairman of the Committee, the General Accounting Office (GAO) issued a report which evaluated the administration and veteran usage of the VA beneficiary travel program. In a 1-day "snapshot" of the program for 166 VA medical facilities, the GAO found that the median cash reimbursement received by veterans per trip was $12.00; the median number of visits by veterans per year was 6.5 (73.5 percent made 1 to 12 trips and the remaining 26.5 percent made 13 or more visits); and special-mode transportation accounted for 44 percent of the costs. Additionally, the GAO reported that fiscal officers at 116 VA medical centers placed local restrictions on beneficiary travel reimbursements and reallocated beneficiary travel funds to other expenses, such as medical supplies, within the medical care account. The annual cost of the program at that time—for fiscal year 1984—was $91.4 million. The statistics regarding the amount of cash reimbursement received by veterans should still be generally valid since the eleven-cents-per-mile rate has not been changed since then.

On March 13, 1985, the VA released a study which had been conducted by Maximus, Inc., on the beneficiary travel program. The study, which was based on evaluations at 18 sites, both rural and urban, reported that 71 percent of program users had service-connected disabilities; 12 percent were veterans in receipt of a VA pension who had no such disabilities; and 12 percent had limited income and no service-connected disabilities. The study found that the median one-way distance traveled by program users was 35 miles and the average one-way distance, 54 miles. It further found that 40 percent of the service-connected disabled veterans and 48 percent of the veterans with no such disabilities traveled 61 miles or more one way; more beneficiary travel program users than non-users had incomes below $10,000; and 35 percent said that they would have been unable to receive VA care if they had not received beneficiary travel payments. Finally, the study found that, among veterans who had made more than 100 outpatient visits to VA health-care facilities during the 12 months preceding the study, 62 percent (which was 7 percent of all beneficiary travel users) said that they needed the travel benefit to maintain their access to VA care.

On April 13, 1987, the VA issued revised beneficiary travel regulations to implement reductions proposed by the Administration in the VA's FY 1987 budget. Initially, in January 1986, the Administration had requested only $10 million for FY 1987 for this program, for which the VA spent $106.7 million in FY 1986. Once FY 1987 began and it became clear that such a reduced funding level was not workable, even for the program as planned to be restricted, the Administration made an additional $58 million available for the beneficiary travel program by realigning to it, within the VA's medical care account, funds that had been intended to be used for capital investments. The resulting $68 million was recently proposed to be increased by a total of $17 million to $85 million. In the joint explanatory statement accompanying the conference report on the FY 1987 Supplemental Appropriations Act (Public Law 100-71), the conferees redirected $10 million to the program, and the VA has proposed that an additional $7 million be reprogrammed to beneficiary travel payments as a result of the delay until April 13, 1987, in the implementation of the new regulations which restricted beneficiary travel payments. For FY 1988, the Administration has requested $51.9 million for this program.

The new regulations as implemented by Department of Medicine and Surgery Circular 10-87-23, date March 31, 1987, effectively eliminated the payment of most beneficiary travel reimbursements except for veterans who meet the general eligibility criteria and require special-mode or emergency transportation and veterans scheduled for compensation and pension examinations. Thus, although not amending the general eligibility criteria, the new regulations permit payment for travel, other than by special mode or in emergencies or for those receiving scheduled compensation and pension examinations, only to those travelling from beyond a 100-mile radius to the nearest appropriate VA health-care facility. No payment is made for ordinary travel of less than 100 miles or less one-way for health care regardless of the cost of the travel or the number of times the veteran must make the trip to receive the needed care. Those living outside the 100-mile radius are charged a deductible—based on the VA's current, 11-cents-per-mile reimbursement rate—of $11 per one-way trip ($22 per round-trip).

Committee bill

Section 101 of the Committee bill, which is derived from S. 1464 as introduced, would take into consideration the special travel-distance needs of individual veterans seeking VA care while reflecting sound fiscal policy. It would require that, if the VA provides any beneficiary travel reimbursement under section 111 in any given fiscal year, then payments must be provided in that year in the cases of travel for health-care services by all of the following beneficiaries: (1) Persons receiving a benefit for or in connection with a service-connected disability (which encompasses all service-connected disabled veterans and all service-connected disabled veterans' dependents or survivors receiving VA benefits, such as dependency and indemnity compensation or VA health-care); (2) a veteran receiving a VA pension under section 521 of title 38; (3) a veteran whose annual income is not more than the applicable maximum pension rate that would be applicable if he or she were eligible for pension benefits; (4) a veteran whom the Administrator determines is otherwise unable to defray the cost of the transportation; and (5) a veteran travelling to receive a scheduled compensation and pension examination.

The Committee bill would also make beneficiary travel reimbursements subject to a deductible administered in the following manner: (1) Veterans eligible for beneficiary travel reimbursement would be subject to a $7.50 per round-trip—$3.75 one-way—deductible amount, which the Administrator would be authorized to increase periodically so as to keep pace with inflation in transportation costs; (2) in the case of veterans pre-approved as needing to make trips for health care more frequently than six one-way trips per month, deductibles would not exceed $22.50 per month, which amount could also be increased periodically; and (3) no deductible would be imposed in connection with special-mode or emergency transportation and travel for a scheduled compensation and pension examination.

In addition, the Committee bill would expressly provide that, when the Administrator determines that it is in the best interest of furnishing VA care, the VA may, prior to determining the beneficiary travel eligibility of a patient travelling by a special mode of transportation, pay the transportation provider subject to the VA subsequently charging the individual for the amount of the payment if found ineligible for the payment.

Further, the Committee bill would require the Administrator to make annual allocations to each health-care facility sufficient to fund beneficiary travel reimbursements pursuant to the basic program. However, two waiver authorities would be provided under which the Chief Medical Director (CMD) could permit individual stations to pay beneficiary travel at a reduced level (including making no payments at all) and instead to expend the funds for direct health-care of veterans. Also, the Administrator would be directed to take all appropriate steps to provide for a transportation program, in conjunction with veterans' service organizations and in cooperation and consultation with the Secretary of Transportation, under which veterans would be transported to and from VA facilities within each VA facility's catchment area.

The Committee notes that the Committee bill provision limiting eligibility for special-mode and emergency travel benefits to those with eligibility based on service connection, pension entitlement, income, or inability to pay is consistent with provisions of current law and VA reguations.

Costs: Based upon cost estimates furnished by the Congressional Budget Office, the overall cost of the beneficiary travel program provided for in the Committee bill, including both the $7.50 round-trip deductible and the $22.50 monthly cap on veteran payments, would be $81 million, $34 million more than the cost of the program under current regulations. This is at least $40—$55 million less than the cost of carrying out the program under the pre-April 13, 1987, regulations would have been in FY 1988.

Deductible: In keeping with that approach and in order to limit the overall cost of this program, the Committee bill includes a provision for a modest deductible of $7.50 per round-trip—$3.75 one-way—for all health-care-related travel other than special-mode and emergency travel and travel for scheduled compensation and pension examinations. Both the deductible amount and the monthly maximum amounts would be increased at the same time, and by the same percentage, as the Administrator increases the rates of allowances and reimbursement pursuant to the provisions in section 111(e) requiring no less frequent than annual reviews and authorizing the Administrator to adjust those rates.

The proposal in the Committee bill also takes into consideration the needs of those beneficiaries who under the new regulations are unable, by virtue of geographic inaccessibility, to obtain health care for which they are entitled or eligible. Under the current regulations, a veteran in Hawaii, Alaska, or the Virgin Islands, may, because of geographic factors, have no choice but to utilize expensive air transportation to reach his or her destination, even for trips of less than two hundred miles round trip. Transportation costs absorbed by these veterans under the Committee bill would be limited to $7.50 per round trip, or $22.50 per month for someone pre-approved by the VA as needing to make frequent trips.

Recognizing that some veterans who are receiving care from the VA must return frequently to a VA facility for health care, the Committee has proposed that, where veterans have been determined in advance to be required to make more than six one-way trips per calendar month to receive health care, the maximum deductible they would pay for travel to the facility in any one calendar month would be $22.50, regardless of the number of trips made. This $22.50 figure—as well as the $7.50 per round-trip figure—could be periodically increased by the Administrator to help meet inflation. This provision would protect veterans receiving frequent treatment for such things as needing kidney dialysis, radiation therapy, chemotherapy, treatment for psychiatric illnesses and PTSD from being denied access to urgently needed health care by virtue of their being unable to pay for their substantial transportation costs. Under current regulations, there is no relief for veterans who must travel to the VA on a frequent basis.

The requirement for advance approval in order for this cap on the monthly deductible amount to apply is designed to avoid the potentially very costly administrative burden of tracking the number of trips made monthly by each potentially eligible veteran.

Reimbursement in Full: As noted above, no deductible would be applied under the Committee bill with respect to travel in medical emergencies, by medically-indicated specialized modes of transportation, or for the purpose of scheduled compensation and pension examinations.

The provision relating to emergency travel recognizes that there are times when an individual's health becomes such that immediate transportation to a medical facility is necessary. It is the Committee's view that the veteran, or his or her family, should not be burdened with the concern of how they might pay for emergency transportation in such time of crisis.

The provision relating to the use of special modes of travel such as a wheelchair van or ambulance, when authorized in advance by the Administrator, is included so as to ensure that veterans who can travel only by such modes have access to VA health care. These and other specialized modes of transportation are common for many disabled individuals, and without special conveyances some veterans would be unable, because of their unique needs, to travel. These special-modes are also very expensive and frequently beyond the means of the average veteran. The Committee notes that payment for emergency and special-mode transportation for otherwise eligible veterans is consistent with the provisions of current law and VA regulations. The Committee does, however, urge the Administrator, in defining special-mode transportation, to give careful consideration to the special needs of various categories of veterans such as those who are blind, paralyzed, or otherwise seriously disabled and unable to utilize public transportation.

Regarding the provision to clarify the VA's authority to pay special-mode transportation providers before determining the patient's eligibility for VA payment for the travel, subject to recovering the payment from the individual if later found to be ineligible, the

Committee notes that so providing these payments—or agreeing to make them—may be important in order to avoid disruptive occurrences that could be very unsettling to the patient and pose major inconveniences to the ambulance company or other provider of special-mode transportation. Private-sector providers of special-mode transportation generally wish to have the assurance of payment that the VA can provide but which a veteran-patient may for a variety of reasons be unable to provide at the time of need for travel to a health-care facility. In the Committee's view, the authority to make, or promise to make, payment should be available so as to ensure that critically-ill or seriously disabled veterans receive emergency and special-mode transportation when they need it without delay or disruption and to maintain effective working relationships with transportation providers.

Finally, with reference to travel in connection with examinations for compensation and pension benefits, the VA has interpreted the authority in current law (section 111 (a)) to pay eligible veterans an allowance based upon mileage traveled for the purpose of "examination" to include, among other things, visits necessary to determine eligibility for compensation and pension benefits. Because the VA's authority to pay beneficiary travel for compensation and pension exams in certain cases may be questionable, the legislation clarifies the existence of that authority.

Waivers: Recognizing that, within the VA health-care system there are 172 hospitals and 226 outpatient centers located in different geographic regions of the country and that each may have unique characteristics, the Committee bill includes provisions under which VA station heads could gain flexibility to administer the beneficiary travel program in a manner they can show would be the most beneficial to the health care of veterans.

The GAO report referred to earlier disclosed that in 1983 there were 116 facilities which were not implementing beneficiary travel programs according to the VA's then current regulations. The Committee has also received reports from field stations to the effect that veterans in certain areas are generally able on their own resources to reach the VA without undue hardship. Thus, at least in some areas of the country, it may not be necessary to implement the provisions of this legislation fully in order to ensure that eligible veterans receive needed care. It is the Committee's intent that any decision at the local station level to seek a waiver to pay less than the full amount authorized for beneficiary travel will be made in consultation with local representatives of veterans' service organizations.

In this regard, the Committee bill would require the VA Administrator to make an annual allocation to each health-care station sufficient to fund the beneficiary travel reimbursement provisions of the bill, and it would provide for two waiver authorities under which individual VA facility heads could be authorized to pay beneficiary travel at reduced levels. First, in those instances where a facility head can demonstrate to the CMD that, prior to the issuance of the new regulations, the facility was making beneficiary travel reimbursements at levels less than those authorized by this legislation, the CMD would be required to allow payments to be made at those levels or at any higher, requested levels, up to the level specified in the legislation. Second, in other cases in which the head of a facility proposes to make payments at a level less than that prescribed in this bill, if the CMD determines that making payments at such a level would be in the best interests of furnishing health-care services to eligible veterans at that facility, the CMD may waive the requirements for paying beneficiary travel as prescribed in the legislation and authorize payments to be made at the level proposed by the facility director or any higher level less than that specified in the legislation. In the case of either waiver, any funds not utilized for beneficiary travel payments would be required to be used for other authorized direct-health-care purposes.

Local Transportation Networks: Finally, as a supplement, or possibly an alternative in some places, to paying beneficiary travel reimbursement, the Committee bill would direct the Administrator to facilitate the establishment of transportation networks in conjunction with veterans' service organizations, as well as to explore the creation of special agreements in cooperation and consultation with the Secretary of Transportation—for example, under section 16(b) of the Mass Transportation Act of 1964, which authorizes grants to assist in providing mass transportation services to meet the special needs of elderly and handicapped persons—under which veterans would be transported to and from VA facilities within each VA facility catchment area.

Veterans' service organizations can be very instrumental in establishing volunteer transportation services for veterans needing this type of assistance. Many of these organizations see this type of program as a natural extension of the services they already provide. In fact, the Disabled American Veterans (DAV) has already begun to place "hospital service coordinators" in VA acute-care facilities to assist in the development and implementation of such networks and has allocated $2 million in grant funds to provide for these programs if the funds are not available locally. Through September 14, 1987, the DAV has placed 96 coordinators within VA facilities.

It is the Committee's hope that local public transit operations might also be encouraged by the Administrator and the Secretary of Transportation to assist veterans needing transportation services to VA facilities. Many of these companies already have special programs for senior citizens or handicapped persons, and the VA may be able to negotiate special rates for certain veterans at a lower cost than they might otherwise have to pay.

Interfacility Transfers: Although payment for interfacility transfer is not specifically referenced in section 111 of title 38, both the new regulations which took effect on April 13 and the old regulations provide authority for payment of interfacility transfer in some, but not all, cases. VA health-care facilities have generally used basic health-care authority, other than section 111, to provide VA facility-to-facility transfers, and it is not the intent of the Committee to make any changes with respect to current practices with regard to payment of this type for travel expense.

TITLE II—QUALITY ASSURANCE PROGRAM

Title II of the Committee bill, which is derived from S. 1443 and S. 1444, would establish an autonomous Office of the Medical Inspector General, with a specified minimum, staffing level, a statutory functional statement, and direct accountability to the Chief Medical Director, which would be charged with investigating reports of inadequate quality of care; establish an Assistant Chief Medical Director for Quality Assurance; and upgrade the monitoring by the VA's independent Inspector General of the Department of Medicine and Surgery's quality-assurance, risk-management, and inspection activities by establishing a new Assistant Inspector General for Health Care Quality Assurance Review with a specified minimum staffing level and a statutory functional statement.

Background

The provision of high quality health-care services is a primary mission of the VA health-care system. In recent years, there has been a growing emphasis on developing ways to determine the extent to which that mission is being fulfilled and to identify problem areas within the VA's Department of Medicine and Surgery (DM&S).

Prior to 1977, DM&S had regional programs to inspect hospitals and review specific issues affecting quality, but the program was not comprehensive and no central system was in place to investigate potential problem areas. In that year, the Administrator of Veterans' Affairs established the position of VA Inspector General (IG) by administrative action, and, in 1978, Congress enacted the Inspector General Act of 1978, Public Law 95–452, which established independent offices of inspectors general within various governmental departments and agencies, including the VA. These offices were, by statute, charged with recommending policies that promote economy, efficiency, and effectiveness and with investigating problems within their agencies related to fraud, waste, mismanagement, and abuse of government property and funds and given the right of access to all material within their respective agencies. However, concerns soon arose that the VA's IG might not have the expertise to evaluate quality of care and professional competence within VA health-care facilities.

At a June 11, 1980, Committee oversight hearing, Chairman Cranston questioned the Chief Medical Director (CMD), the IG, the witness representing the Association of American Medical Colleges (AAMC), and physicians working with medical schools affiliated with the VA, concerning the IG's capacity to investigate health-related matters as well as regarding a VA proposal to establish an Office of the Medical Inspector within DM&S to monitor quality-of-care issues. The VA's CMD and the AAMC witness testified in support of establishing this office, stressing the tradition of peer review and the appropriateness of investigations into health services being performed by persons with a background in medicine. In addition, the CMD argued that, under title 38, United States Code, the CMD has clear responsibility for the surveillance of professional performance and quality of medical care, including the responsibility to investigate untoward incidents. The CMD also noted that, because of the mandated responsibility in title 38, any office established to oversee and evaluate the quality of health care within DM&S should rightfully report to the CMD. In contrast to this viewpoint, Chairman Cranston, as well as the witness representing the General Accounting Office, expressed concerns during this hearing about the independence and perceived objectivity of such an investigative entity located within DM&S.

At that same hearing, Chairman Cranston raised concerns with regard to the specific duties of the IG—especially relating to quality of health-care issues. He questioned the then-IG, Allan Reynolds, concerning the viability and desirability of establishing in the IG's office a medical unit responsibile for investigating quality of care and compentency issues. The IG stated that the volume of work would not be sufficient to warrant the range of staff which would be required of such a unit and that it would be difficult to hire professionally-qualified staff to perform these types of activities on a full-time basis.

On September 22, 1980, the VA established the Office of the Medical Inspector—with the Medical Inspector reporting to the CMD and having the responsibility to monitor the quality of care within DM&S. One year later, DM&S's Evaluation and Analysis Office, which was charged with systemwide, systemic evaluations of VA care, was combined with the Office of Medical Inspector to form the Medical Inspector and Evaluation Office. The head of this office, the Medical Inspector (MI), was thus given responsibility for all functions pertaining to the monitoring and evaluation of quality of care provided by DM&S, including the investigations of specific incidents involving a VA patient and the evaluation of the overall quality of care provided at VA hospitals.

As a result of IG office requests, which began in November 1982, to formalize relationships between the IG and the MI, agreement was reached in December 1984. The "Statement of Responsibilities and Relationships Between the Office of Medical Inspector and the Office of Inspector General" defined the purposes, applicable authorities, responsibilities, and collateral endeavors of both offices. The document, signed by the CMD and IG, recognized the "Congressional concerns regarding the establishment and placement of the Medical Inspector's Office in the Department of Medicine and Surgery, the independence and objectivity of the Medical Inspector, and the necessity for Inspector General oversight".

On December 21, 1983, then-Committee Chairman Simpson requested the GAO to conduct a review of the Medical Inspector and Evaluation Office in order to provide the Committee with information regarding the general operation and effectiveness of the MI's Office. GAO was also asked to examine the functions and relationships of the MI, VA medical center directors, the CMD, and the IG relating to quality assurance in the VA's health-care system.

Subsequent to that request, on June 6, 1984, the Committee held an oversight hearing to receive testimony on the VA's policies and practices relating to quality assurance, including the role of the MI in ensuring the implementation of quality-assurance policies and the monitoring of quality-assurance activities. The Committee was concerned about many issues, including (1) the priority accorded within DM&S to the MI's mission, to ensuring the availability of sufficient resources and sufficient personnel to enable the MI to accomplish this mission, and to enhancing the independence of the MI; and (2) the role of the IG in monitoring the quality-assurance activities of the MI.

In follow-up to the previous GAO request, the June oversight hearing, and subsequent meetings of GAO and Committee staff, then-Committee Chairman Murkowski and then-Ranking Minority Member Cranston jointly requested, on September 6, 1984, that GAO expand its ongoing review of the Office of the Medical Inspector and Evaluation to include, among other things, (1) the relationship between the MI and the IG, (2) the protection of DM&S employees who report quality-of-care deficiency incidents, and (3) the resources allocated to the MI.

GAO's report, entitled "VA Has Not Fully Implemented Its Health Care Quality Assurance Systems", was released on June 27, 1985. It found, first, that VA medical centers had not implemented the quality-assurance programs required by VA regulations and, second, that the MI was not evaluating the effectiveness of the centers' programs. Specifically, GAO found that the 13 VA facilities examined either did not perform or only partially carried out the five quality-assurance functions mandated by VA regulations. These functions were (1) continuous monitoring of 15 separate clinical elements; (2) patient injury control; (3) utilization review; (4) problem-focused health-care studies; and (5) review of the credentials of health-care professionals. The report stated, "As a result, the centers did not systematically (1) determine whether health care and services provided were appropriate to patient needs, (2) determine patterns and trends of health care provided, and (3) resolve systemic quality of care problems." More importantly, the GAO found that the MI was not evaluating the effectiveness of the programs at the medical centers reviewed.

With respect to the specific questions asked by the Committee, the GAO found that (1) medical centers were not reporting incidents to Central Office as required by regulations, although incidents were generally being reported at each individual center; (2) an incentive program was in place to encourage employees to report incidents of fraud and waste in general, but no such program existed for reporting incidents of poor quality care; and (3) improved relationships and communications existed between the MI and IG since the responsibilities and relationships of the Offices had been formalized in December 1984. The GAO also found that medical centers were adequately safeguarding information about employees who did report incidents. In response to questions regarding the resources allotted to the MI to carry out the functions of his office, the GAO reported that the MI indicated that, since he had access to professional and other staff within the VA, the three full-time-employee equivalents (FTEE) provided to him—one professional and two support persons—were adequate. Additionally, the GAO reported that an official of the MI's office said the MI had adequate travel funds to conduct investigations. The GAO did not offer its own evaluation of the adequacy of MI staffing.

Earlier, on March 3, 1985, the CMD, in an effort to place additional emphasis on quality assurance and in anticipation of the issuance of the GAO report, had established the Office of Quality Assurance in DM&S. This new office, responsible directly to the CMD, assumed many of the quality-assurance responsibilities of the Medical Inspector and Evaluation Office, which was abolished at that time, and was intended to provide a more prospective means of identifying and dealing with potential quality-of-care problems before incidents occurred. The investigative functions and the Patient Injury Control Program continued in the new Office of the Medical Inspector, which reported to the Deputy Chief Medical Director.

In addition to monitoring the activities of the IG and MI, the Committee has maintained a high level of interest in the overall appropriateness of health care furnished by DM&S and, more specifically, in the morbidity and mortality rates experienced in the VA as compared to private sector facilities. In this regard, the Committee concluded in 1985 that an effective quality-assurance program is an essential component of the provision of high quality health-care services for veterans and should therefore be included as a specific DM&S function in title 38.

On July 8, 1985, the Committee favorably reported, as part of S. 876, certain provisions relating to quality assurance. These provisions were enacted on December 3, 1985, in section 204 of Public Law 99-166. Among other things, these provisions required the VA to compile and analyze DM&S morbidity and mortality data for surgical programs and medical center data for certain specific surgical procedures in light of specific patient characteristics and the level of risk of the surgical procedure involved and to report to Congress the results of that study. By specifically requiring the VA to analyze such data before its release, the Committee believed that the chances of the raw data being misinterpreted would be substantially reduced and that the data and its interpretation could serve as a useful quality-assurance indicator.

Also, because of concerns about the adequacy of VA efforts to ensure that its health-care professionals were fully qualified, this legislation required the VA to submit a report on its efforts in that regard, including its arrangements with appropriate entities to obtain accurate information to verify the credentials of health-care professionals—both those already on board as well as applicants for VA employment.

The first of three required VA reports comparing the VA's surgical morbidity and mortality experience with that of the private sector was released on April 1, 1987. In that report the VA noted that "an effective quality assurance program depends upon an effective system of data collection, analysis, and reporting." The Chairman has asked the Congressional Office of Technology Assessment to analyze and comment on that report.

In response to an August 30, 1985, request made by then Committee Chairman Murkowski, the GAO conducted a study of the VA's Patient Injury Control Program in follow-up to the earlier quality-assurance report. That program, overseen by the MI, involves (1) reporting incidents that would not be considered a natural consequence of a patient's disease process or illness; (2) investigating certain incidents to determine why they happened and whether they can be prevented from recurring; and (3) analyzing patient incident trends that may indicate problems requiring further study or corrective actions.

The GAO report, entitled "VA's Patient Injury Control Program Not Effective", which was released on May 18, 1987, found that at the nine VA facilities visited, 86 percent of the incidents which, according to VA regulations, are required to be reported were not reported in ways required by those regulations. Hence, important corrective actions were not being taken that would protect the health of other veterans receiving VA health care. GAO identified several factors as contributing to the ineffectiveness of the program, including employee disincentives associated with reporting and "inadequate guidance and limited oversight" on the part of the MI.

On May 20, 1987, Ranking Minority Member Murkowski, Chairman Cranston, and the GAO held a joint press conference to announce the results of the study. At that time, the Chairman and Ranking Minority Member indicated that extensive follow-up would be undertaken, involving experts in the field of quality assurance and patient-injury monitoring and personnel responsible for the Defense Department's quality-assurance program, to explore alternatives for improving DM&S's system of monitoring serious patient injuries, to emphasize the importance of this function in the field, and to find the best organizational arrangement within the VA's Central Office to facilitate the implementation and monitoring of the quality-assurance and risk-management programs.

It was pointed out by the GAO at the press conference that the GAO findings regarding a failure of the VA medical centers to report incidents of patient injury to the Central Office did not mean that the quality of the patient care being provided was inadequate. It was also stated in the report that the VA's regulations provided an adequate basis for initiating a Patient Injury Control Program, but that DM&S needed to provide its medical centers with additional implementation guidance.

A meeting was held on May 29, 1987, involving Committee staff, the IG, CMD, Deputy CMD, MI, and Director of Quality Assurance for the VA, a representative of the Department of Defense (DOD), and staff from the GAO. The organization and functioning of the VA's present quality-assurance and risk-management programs were discussed in detail, including the perception that the VA was not open to external inspections and that the agency has responded to the need for changes in its quality-assurance program only as a result of public pressure. The process of inspection and oversight for military hospitals was described in detail and it was noted that, in some instances, the service equivalent of the IG reported to the service commander responsible for the hospitals and, in other instance, the IG equivalent reported to a commander outside of that system. The DOD representative indicated his belief that neither organizational structure operated better than the other and that all arrangements could function well. At that meeting, the CMD again stressed his statutory accountability for care provided in VA health-care facilities and his very strong belief that peer review of physicians should be the responsibility of the CMD.

Committee bill

In response to all of the prior activity in this area, including the May 29 meeting, the Chairman and Ranking Minority Member developed complementary bills, S. 1443 and S. 1444, which have been melded together in title II of the Committee bill to (1) establish statutorily the Office of the Medical Inspector General (MIG) in the Office of the CMD and make the MIG directly accountable to the CMD; (2) require the MIG to be a physician who would be appointed for a term of 4 years, removable only for cause; (3) require the office of the MIG to be staffed by not less than five Assistant MIGs who must be full-time VA physicians, dentists, or registered nurses, by not less than two full-time VA registered nurses (including any nurse who is an Assistant MIG), by not less than one full-time VA dentist (including any dentist who is an Assistant MIG), and not less than five full-time support personnel; (4) require the Administrator to transfer to the MIG ten FTEEs and such funds as are designated by the CMD to be necessary to support the statutorily-mandated positions; (5) except for those instances where the Administrator or the CMD specifically requests an investigation, give the MIG sole discretion as to which investigations to conduct; (6) require that all MIG investigations conducted by personnel from outside of the medical facility being investigated include at least one Central Office MIG professional staff member; (7) require that the MIG be a member of all DM&S policy-making bodies relating to the quality of care and quality-assurance programs; (8) require the MIG to make annual reports regarding the activities of the MIG for the preceding fiscal year; (9) require the establishment of an Assistant Chief Medical Director for Quality Assurance; (10) require the CMD to issue regulations prescribing appropriate disciplinary action when employees fail to comply with reporting requirements relating to the quality-assurance program; (11) establish in the Office of the VA's IG an Assistant Inspector General for Health Care Quality Assurance Review (AIG); (12) require the AIG to (a) monitor the establishment and implementation of quality-assurance and risk-management programs; (b) monitor the activities of the MIG and recommend the conduct of needed investigations, as well as coordinate activities with those of the MIG; (c) review MIG investigations and recommend appropriate additional action; (d) monitor and analyze the collection and analysis of quality-assurance and risk-management data, determine if additional data should be collected, and monitor the analysis and trending of data relating to the provision of health-care services; (e) make recommendations to the IG for corrective action on health-care matters and monitor the implementation of the recommendations made by the IG to the Administrator; and (f) perform any other IG duties as directed by the IG; and (13) require that the Office of the AIG consist of at least 13 full-time employees to include at least two doctors of medicine, and a minimum of one of each of the following: a doctor of dental surgery or medicine, a registered nurse, a health-care attorney, a person with expertise in quality assurance and risk management, and a health-care administrator.

Establishment of the Office of Medical Inspector General: Section 201 of the Committee bill would establish the Office of the MIG in the Office of the CMD. As was discussed above, since the inception of the MI office, the Committee has questioned the advisability of the office remaining within DM&S versus the feasibility of moving this investigative function to the IG. Because the CMD is clearly ultimately accountable under law for the quality of care provided to veteran-patients, and since one aspect of ensuring such quality is to investigate questionable practices in the provision of clinical services, the Committee is satisfied for the time being to leave this investigative function in the hands of an official reporting directly to the CMD as long as safeguards such as these proposed in the Committee bill are put in place to ensure the autonomy and resources of the office. If it is found in the implementation of this legislation that a substantial enhancement of the operations of the investigative function currently performed by the MI is not forthcoming, the Committee will consider further whether there is a need for legislation to assign investigative responsibility to the Office of the Inspector General.

Because the MIG must have the capability to make credible medical judgments, the Committee bill would require the MIG to be a physician. To provide protection from retribution from those who disagree with the conduct of an investigation or a decision forthcoming as a result of a MIG investigation, the Committee bill specifies that the MIG be appointed by the Administrator, upon the CMD's nomination, for a tenure of 4 years, and be removable only for cause, in the same way as are Assistant Chief Medical Directors, for example.

The Committee has been concerned for many years about the level of resources available to the MI and the background and training of those assigned to carry out or monitor investigations. To address this concern, the Committee bill would mandate a minimum number, and the qualifications, of employees in the MIG office.

Specifically, the office would be required to be staffed by not less than five Assistant MIGs who must be full-time VA physicians, dentists, or registered nurses, by not less than two full-time VA registered nurses (including any nurse who is an Assistant MIG), by not less than one full-time VA dentist (including any dentist who is an Assistant MIG), and not less than five full-time support personnel. Such a mix of staff, in the Committee's view, should provide the necessary diversity of skills to enable the MIG to carry out, and to analyze the required information obtained, in such investigations. Further, this measure would mandate that the Administrator transfer to the MIG—from funds other than those appropriated to support the Central Office operation of DM&S—the funding and employment authorization to support at least ten MIG positions.

The Committee bill would provide the autonomy of the MIG by authorizing that office to carry out investigations deemed necessary by the MIG, without obtaining prior approval from either the CMD or the Administrator. Conversely, although the measure provides for the Administrator or CMD to request an investigation that either one deems necessary, the Administrator or the CMD would not be permitted to prohibit an investigation. This protection should help prevent accusations that an investigation was not made because the operating VA officials were attempting to hide or "cover up" an incident.

In order to discourage the Administrator or CMD from overwhelming the MIG with management-prescribed investigations, to the point of preventing the MIG from studying other potential problems on his or her own initiative, the Committee bill would also require the MIG to delineate in a mandated annual report, described below, the number of investigations, and the total resources devoted to them, which were requested by the Administrator or CMD and the number which were self-initiated.

The bill would further provide that, when an investigation team is sent into the field to interview staff and review documentation, a member of the MIG office would be a part of the team. At present, when a site visit is carried out to determine the facts in a particular case, staff from other facilities within the VA generally are assigned to conduct the investigation. Although such visiting experts may have technical knowledge within their specialties, they often lack training in investigative procedure and, more importantly, may feel pressure—inadvertent or advertent—from their peers to dilute their findings. It is difficult to rely entirely on the objectivity and aggressiveness of a field investigation by DM&S employees who one day are critiquing the work of others and who, the next day, may be assigned to work with those they are critiquing and who know that that is the way the system operates. This factor should be mitigated by having a member of the MIG office as a member of each site-visit team.

The Committee bill would specify that the MIG may not be assigned direct responsibility for quality-assurance activities, including patient risk management and the reporting of patient injuries under quality-assurance procedures. However, the bill would mandate that the MIG be an *ex officio,* non-voting member of all Central Office policymaking committees which address quality of care or quality-assurance issues. Thus, the Committee has acted to avoid a real or apparent conflict of interest raised by the MIG having direct responsibility for any programs within DM&S that he or she would have responsibility for investigating. At the same time, the Committee bill seeks to lend expertise and concrete information to quality-assurance policy-making activities by including the MIG in all pertinent quality-assurance, risk-management, and heath-care-quality discussions.

The MIG would be required to submit to the Administrator, the CMD, and both Committees on Veterans' Affairs, by February 1 of each year, a report describing the activities of the MIG office over the preceding year, including the outcome of MIG recommendations for remedial or disciplinary action and an assessment of the effectiveness of that office, and, as described above, a listing of those investigations which were self initiated and those which were assigned by the Administrator or CMD. The Committee is very interested in the scope and types of problems occurring in the VA health-care system and, more importantly, what is being done to correct and prevent these problems from recurring. This annual MIG report should help the Committee maintain effective oversight of these issues.

Assistant Chief Medical Director for Quality Assurance: It is evident from the 1985 and 1987 GAO reports discussed above that DM&S is not meeting the goals and objectives it has established for itself in the area of quality assurance. This lack of emphasis contrasts with action in the private sector placing greater stress on quality-assurance activities. Because of the impact that quality-assurance and risk-management programs have on the operations of a hospital, private sector hospital boards of directors are now requiring in-depth quality assurance analyses and reports to be provided to them. The Joint Commission on Accreditation of Hospitals is also giving quality assurance more prominence than it has in the past. In this regard, the Commission is developing clinical indicators which will be used as measures of quality care when each facility is surveyed by Commission representatives.

To provide a similar emphasis in DM&S, section 202 of the Committee bill would upgrade quality-assurance activities in DM&S by establishing the position of ACMD for Quality Assurance charged with carrying out the responsibilities assigned to the CMD under subchapter V of Chapter 17 of title 38, which include data collection, evaluations, and reports regarding VA mortality and morbidity rates for surgical procedures and other quality-assurance responsibilities which have been delegated to the CMD by the Administrator.

The establishment of this position at the level of ACMD is intended to provide a greater impetus to and support for those in the field carrying out quality-assurance activities. By placing the function of quality assurance and risk management at this high level within the organization, Congress would be sending a message to both employees within DM&S and the general public that quality is an important goal and one that is to be actively pursued. It is the Committee's intent that the ACMD for Quality Assurance be assigned general responsibility for quality-assurance programs and systems, such as those outlined in 38 C.F.R. sections 17.500–17.540, and develop and improve upon them based on new developments in the field of quality assurance. In this regard, the Committee notes that it considers programs which provide for the safety of patients and the review of the appropriateness of patient care as primary functions of any quality-assurance program.

Individual DM&S Employee Responsibilities for Implementation of the DM&S Quality-Assurance Program: Section 203 of the Committee bill would require the CMD to issue regulations prescribing disciplinary action in those instances in which employees fail to comply with reporting requirements relating to the quality-assurance program. As previously discussed, the GAO reported that many patient-injury or adverse occurrences were not, because of a variety of reasons including disincentives associated with reporting, reported according to established policy. Although the Committee believes these fears are understandable, it also feels strongly that, in order to have an effective quality-assurance program, employees must understand and fulfill their responsibilities in the areas of problem detection and reporting. Equally important to an effective quality-assurance effort is a program to promote greater quality-assurance awareness on the part of health-care staff through major educational efforts and the development of a creative program to reward positive behavior.

Establishment of the Assistant Inspector General for Health Care Quality Assurance Review: In view of the critical importance that an effective quality assurance program plays in the delivery of quality of care, the Committee believes that independent oversight of quality-assurance programs is necessary. Accordingly, section 204 of the Committee bill would amend section 250 of title 38 to establish in the IG's office the position of Assistant Inspector General for Health Care Quality Assurance Review. The primary responsibilities of this new position would be to (1) monitor the establishment and implementation of quality-assurance and risk-management programs, through, among other activities, on-site reviews of VA health-care facilities; (2) monitor the activities of the MIG and recommend the conduct of investigations, as needed, as well as coordinate activities with those of the MIG; (3) review MIG investigations and recommend appropriate additional action; (4) monitor and analyze the collection and analysis of quality-assurance and risk-management data, determine if additional data should be collected, and monitor the analysis and trending of data relating to the provision of health-care services; and (5) make recommendations to the IG for corrective action on health-care matters and monitor the implementation of those recommendations which the IG makes to the Administrator. The Assistant IG would also perform such other IG functions as may be directed by the IG.

The Office of the Assistant IG for Health Care Quality Assurance Review would consist of at least 13 full-time employees to include at least two doctors of medicine, and a minimum of one of each of the following: a doctor of dental surgery or medicine, a registered nurse, a health-care attorney, a person with expertise in quality assurance and risk management, and a health-care administrator. This interdisciplinary team is designed so as to have the medical expertise and experience to effectively perform the functions of the office and to cooperate and exchange ideas with the MIG.

The Committee does not intend for the Assistant IG for Health Care Quality Assurance Review to duplicate the work of the Medical Inspector General. The Committee believes it may become necessary, upon occasion, for the Assistant IG, in the course of carrying out responsibilities under the legislation, to visit health-care facilities and, through reviews, analyze independently data obtained there in order to test the reliability of that data and investigations carried out by DM&S in the course of its quality-assurance, risk-management, and inspection programs.

Finally, the Committee bill would require a report, not later than Febrauary 1 of each year, to the Committees on Veterans' Affairs, on the activities of the Assistant IG. This report would be required to include a discussion of the activities of this Office, findings and conclusions resulting from those activities, recommendations made to the Administrator for corrective action, corrective action taken with respect to those recommendations, and a discussion of the specific activities undertaken to monitor the MIG.

TITLE III—VIETNAM VETERANS' READJUSTMENT COUNSELING PROGRAMS

Title III of the Committee bill, which is derived from S. 1501, contains several provisions relating to the VA's Readjustment Counseling Program for Vietnam-era veterans and, more specifically, to the mandate in current law that the program undergo a 2-year transition beginning October 1, 1987, from a program providing services primarily through vet centers—generally storefront facilities situated in local communities apart from general VA facilities—to a program providing such services primarily through such general VA health-care facilities, such as medical centers and outpatient clinics.

Background

History of legislation.—Public Law 96-22, the Veterans' Health Care Amendments of 1979, required the VA to provide readjustment counseling to Vietnam-era veterans. Under that law, eligible veterans had 2 years from the date of their discharge or, for those discharged prior to 1979 (the vast majority of Vietnam-era veterans), 2 years from the October 1, 1979, effective date of that law (that is, until September 30, 1981), to request readjustment counseling from the VA.

The VA opened the first vet center in December 1979. By the end of 1980, 87 vet centers were in operation. Subsequently, funds were appropriated to establish additional centers—first to a level of 136 centers (the 136th was opened in early 1983) and then to the current level of 189 centers (the 189th was opened in October 1986), one of which (in Wilmington, Delaware) was relocated to a VA medical center in May 1987. Through FY 1987, Congress has appropriated $206.2 million for the provision of readjustment counseling.

In 1981, Pubic Law 97-72 extended the period of entitlement to request readjustment counseling by 3 years, until September 30, 1984. That law also mandated the VA, beginning on September 30, 1983, and ending on September 30, 1984, the new expiration date for requesting counseling, to take the necessary steps to accomplish an orderly transition in the Readjustment Counseling Program from one providing counseling and other services primarily through vet centers—which, as was noted above, are facilities situated apart from traditional VA health-care facilities—to a program providing such services primarily through traditional VA health-care facilities. The VA was also mandated to submit a report to Congress by April 1, 1984, on its plans in that regard. As was stated in the Explanatory Statement which the House and Senate Veterans' Affairs Committees inserted in the *Congressional Record* in both Houses during the debates on final passage of the legislation that was enacted as Public Law 97-72 (see p. H 6814 of the *Congressional Record* for October 1, 1981, and p. S 11574 of the *Congressional Record* for October 16, 1981), this transition process was mandated in order to ensure that there would be an ongoing capacity within the VA to provide the mandated readjustment counseling services to those veterans who had requested such services prior to the expiration date and thus were eligible to complete necessary counseling.

Public Law 98-160, enacted in 1983, made the entitlement to readjustment counseling permanent by removing any fixed date by which counseling had to be requested and postponed the deadline for beginning the program transition to October 1, 1987, and the deadline for the transition report to July 1, 1987. In addition, that law required the VA to conduct a study—and to submit to the Committees on Veterans' Affairs a report thereon by October 1, 1986—of the prevalence and incidence among Vietnam veterans of post-traumatic stress disorder (PTSD) and other psychological problems in readjusting to civilian life. The Administrator was also mandated to submit a report by April 1, 1987, evaluating the effectiveness of the readjustment counseling program and providing the Administrator's recommendations for the future of the program, giving particular attention, in light of the results of the PTSD/other-postwar-psychological-problems study, to the provision of readjustment counseling and related mental health services to veterans with PTSD and to the diagnosis and treatment of PTSD.

Finally, Public Law 99-576, enacted in 1986, extended the deadline for completing the program transition by 1 year, until October 1, 1989, and required that the transition take place in a "gradual", as well as "orderly", manner over the course of what thus was made a 2-year, rather than 1-year, transition period. That law also modified the April 1, 1987, and July 1, 1987, reporting requirements, described above, to require that the administrator take into account so much of the PTSD/other-postwar-psychological-problems study results as were available at the time the reports were to be submitted, and mandated a third, mid-transition report, due by February 1, 1989, on the results of the first year of the transition.

Thus, as a result of these various laws, there are a number of milestones in current law which are related to a process whereby the existing readjustment counseling program is scheduled to undergo an orderly and gradual 2-year transition beginning October 1, 1987, from a program providing services primarily through the vet centers to a program providing such services primarily through general VA health-care facilities, such as medical centers and freestanding outpatient clinics. The "primarily" criterion has been construed by the VA's General Counsel—in a 1986 White Paper—to require that by the end of the transition period a majority of readjustment counseling programs must be operated at traditional VA facilities. The Committee agrees with this interpretation.

As was noted above, the first of the milestones relating to the transition was October 1, 1986, the date by which the Administrator of Veterans' Affairs was required to submit to the two Veterans' Affairs Committees a report on the results of the PTSD/other-postwar-psychological-problems study. As was also noted, following that report, and taking the results of the study into consideration, the Administrator was required under current law to submit two additional reports—one on April 1, 1987, and the other on July 1, 1987—before the transition period was to begin.

VA reports and recommendations regarding program.—This first report, which was due on April 1, 1987, and sent to the Committee under cover of a July 9, 1987, letter, was to set forth the Administrator's evaluation of the program's effectiveness in helping to meet the readjustment needs of Vietnam-era veterans, the Administrator's opinion on the extent to which the readjustment needs of Vietnam-era veterans remain unmet, and the extent to which vet centers are needed to meet that need. The second report, which was due on July 1, 1987, and sent to the Committee under cover of an August 3, 1987, letter, was to set forth the Administrator's plan for accomplishing the transition required by current law to take place gradually during fiscal years 1988 and 1989.

With respect to the April 1/July 9 report, the Committee notes that the Administrator recommended no change in the current-law transition requirement but instead recommended that the relocation process go forward. This recommendation was in contrast to the results of 3 other evaluations of the Vet Center program which are summarized in an appendix to the April 1/July 9 report. Specifically, the report describes the work of the VA's Department of Medicine and Surgery Vet Center Planning Committee and characterizes its January 1986 recommendations as follows—

—The present Vet Center Program should be continued after Fiscal Year 1988 with no major alterations in structure, services, or eligibility.

—The Committee recommended that the Veterans' Administration should forward a legislative initiative to remove the concept of a general disbanding of vet centers, substituting a provision indicating that the availability of readjustment counseling services will be provided by the VA in a manner determined by the Agency.

The VA Advisory Committee on Readjustment of Vietnam Veterans also was asked to evaluate the Vet Center Program and to make recommendations about its future. In January 1986, the Advisory Committee "endorsed the recommendations ultimately approved by the Planning Committee" (described above), and, according to the VA report, in September 1986, after being asked by Administrator of Veterans' Affairs Thomas Turnage to again review the program, the Advisory Committee responded as follows:

—The Committee recommends that the Vet Centers, as a unique community-based delivery system, be made a permanent part of the DM&S health care organization.

—The Committee recommends that the Administrator seek legislative authority to expand the eligibility criteria for Vet Center services to include veterans of all eras.

—The Committee recommends that the Administrator initiate several pilot projects at designated Vet Center sites designed to expand the Vet Centers into general community-based VA resource centers inclusive of other DM&S and DVB functions, as indicated appropriate by needs assessment and outcome evaluation.

Finally, the April 1/July 9 report describes the work of the Chief Medical Director's Special Committee on Post Traumatic Stress Disorder. According to the report, that committee made the following recommendations in its most recent report, described in the VA report as "The Special Committee's 1987 Report":

—The Special Committee recommends that Readjustment Counseling Service and its vet centers, as a unique and valuable community based delivery system, be preserved and incorporated into the changing organizational matrix and service delivery patterns of the VA's Department of Medicine and Surgery.

—Program's mission should be comprehensively reviewed and clarified.

—Vet center staff should be given career appointments as VA employees so that they may provide service to veterans without fear that their jobs will be terminated in the near future.

—Quality Assurance criteria should be established and utilized to monitor operations.

—Legislative authority should be sought "to expand the eligibility for services from vet centers to include combat veterans from all wars."

In addition to not being in accord with these prior evaluations of the program, the recommendation in the April 1/July 9 report to go ahead with the transition also conflicts with various other statements in the report, including the following:

> Our evaluation as of 1987 is that the VA Readjustment Counseling Program is quite effectively carrying out the mission designed for it by the Congress and the VA.
>
> * * * * * * *
>
> If the VA's ongoing assumption, based on the two major epidemiologic studies conducted in 1977 and 1979, [is correct] that 700,000 to 800,000 veterans formed the target population for this program, and if the target population has neither expanded nor declined in the interval, the readjustment counseling program has to date seen slightly over half of the target population.
>
> * * * * * * *
>
> Vet centers were implemented by the agency in 1980 with some urgency, in an effort to relieve a disturbing and troubling situation which had arisen among some returnees from the nation's most recent war. The model is effective in accomplishing that purpose. In addition, however, the operation and refinement of the program during the past seven years has provided a challenge for the Agency in organizational development. The program has brought the VA generally closer to the community, and has fostered the perception, among both Vietnam era veterans and veterans of other wars, of the Veterans Administration as flexible and responsive.

These statements from the VA's report, together with the recommendations from other evaluations discussed above, seem more consistent with a decision to repeal the transition requirement rather than one to go forward with it. It is the former course that the Committee bill proposes along with provisions to carry out most all the other recommendations from the various review groups.

The Administrator's July 1/August 3 report describes in outline the VA's plans under current law for relocating vet centers to general VA facilities on a gradual and orderly basis over the 2-fiscal-year period, 1988–1989. This plan calls for 8 centers to be relocated in the first quarter of fiscal year 1988 (October-December 1987), with the number of centers relocated in subsequent quarters increasing by one center each quarter through the third quarter of fiscal year 1989, and then with 18 centers proposed for relocation in the final quarter of fiscal year 1989 for a total of 95 centers relocated and none closed over the 2 years.

Delay in PTSD Study.—One possible explanation of the apparent contradiction between the content of the report and its principal conclusion lies in the lack of availability of the major PTSD/other-postwar-psychological-problems study report, due last October 1. As the April 1/July 9 report indicates, this study is not yet available and the "report has been prepared in advance of any results of the [PTSD report] and thus cannot reference them. Its conclusions must therefore be understood to be tentative."

The Committee notes, as it did in its report accompanying S. 477 (S. Rept. 100-15, p. 26), that the approach in current law of a comprehensive study together with sequenced reports was designed to enable the Congress to make informed decisions about the future of the Readjustment Counseling Program, including the nature and timing of its integration into other VA health-care facilities. However, as just noted, the underlying PTSD/other-postwar-psychological-problems study on which this process was to be based has been delayed and the initial report on that study is not expected to be submitted until approximately October 1 of this year.

As a result of this delay in the PTSD/other-postwar-psychological-problems study, this Committee ordered reported on February 26, reported on March 18, and the Senate passed on March 31, in S. 477, legislation to postpone the vet center transition for one year.

Administration opposition to Vet Center Program.—However, since that time, the Committee has grown increasingly concerned that a simple delay is not the right course and that, insead of a requirement that a fixed number of vet centers undergo a transition within a fixed period of time, the law should be amended to provide that any change in the status of an individual vet center should be carried out only after a careful, case-by-case, analysis results in a decision that the purposes of the Readjustment Counseling Program and the mission of the VA can best be served by moving a vet center to a VA medical or other facility rather than by maintaining its community-based location. This is the course proposed in the Committee bill.

Not only does such an approach represent, in the Committee's view, a more appropriate approach to the future of the Readjustment Counseling Program, but it also helps guard against arbitrary changes in the program. This latter element is particularly important in light of what seems to be a renewed hostility toward the program by this Administration and the current political leadership in the VA. In March 1981, the Administration proposed, in its first budget request to the Congress, to eliminate all funding for the Vet Center Program as of September 30, 1981, and opposed legislation to extend beyond FY 1981 eligibility to request counseling; it later opposed legislation to extend until September 30, 1984, eligibility to request counseling. Congress rejected all of these recommendations from the President and, as noted above, extended eligibility through FY 1984. In 1983, with the support of Administrator of Veterans' Affairs Harry L. Walters the 1-year mandatory transition of the vet centers was postponed from FY 1984 to FY 1988.

The Administration's negative attitude toward vet centers, which had been largely held in abeyance under the 3-year VA leadership of Administrator Walters, during 1983-1985, surfaced again early this year in the extraordinarily hasty and haphazard decisions made in late Janaury in the name of current Administrator Thomas K. Turnage to relocate 9 vet centers beginning on July 1. Those relocations were blocked by order of the U.S. District Court for the District of Columbia (*Vietnam Veterans of America* v. *Veterans' Administration,* Civil Action No. 87-1610) until October 1, 1987, (although one center, in Wilmington, Delaware, was relocated prior to the Court's order). Another recent manifestation of this animosity is the recommendation in the Administration's April 1/July 9 report to go ahead with the transition even though much of the tenor of the rest of that report, as described above, speaks to a continuing need for readjustment counseling and the vet centers as effective in providing it and the VA's Chief Medical Director, it is generally understood. recommendded that the VA proposed legislation to repeal the mandatory transition requirement.

With specific reference to the proposed relocation of the 9 vet centers, the VA's Chief Medical Director, Dr. John A. Gronvall, in his June 18 response to Chairman Cranston's May 11, 1987, letter, set forth the criteria which supposedly were used in selecting the 9 centers (these same criteria are also included in the Administrator's April 1/July 9 and July 1/August 3 reports) and provided specific information on the proposed relocation of each center. (The letters are reprinted below.)

The Committee is particularly concerned that only 2 of these 9 vet centers were planned to be relocated into buildings at the general VA facility where the vet center will be the only occupant of the building. Even more distressing is the indication in Dr. Gronvall's letter that 5 of the centers were planned to be relocated in close proximity to an existing Mental Hygiene Clinic at the VA facility. The obvious impression that such an arrangement may create—that a vet center is simply another mental-health facility and that those being furnished services through the program suffer from mental illness—is one that has been wisely and deliberately avoided since the inception of the program in 1979 and one which the Committee believes should continue to be resisted at this time as well.

With further reference to the proposed relocation of the 9 centers, the Committee has been advised that there is significant opposition to some of the proposed relocations, including from officials at medical centers to which the vet centers would be relocated. Also, despite the fact that the VA's criteria call for assessments by local vet centers regarding the feasibility and workability of a proposed move, a participant in the *Vietnam Veterans of America* v. *Veterans' Administration* lawsuit, mentioned above, submitted a declaration to the court which noted, among other things, that "eight of the nine Vet Centers Directors admitted that they were not consulted by VA officials regarding the decision to relocate their Vet Center prior to the decision."

The exchange of correspondence between the Chairman and the Chief Medical Director follows:

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

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United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

May 11, 1987

Dr. John A. Gronvall
Chief Medical Director
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear John,

I am writing in follow up to your February 17, letter regarding the agency's plans to relocate nine Vet Centers from their locations in community facilities to locations at their support VA Medical Centers. I am also interested in gaining clarification of the testimony of the Administrator at the Committee's February 18, 1987 hearing regarding these Centers.

I. With general reference to the nine Vet Centers which have been selected for transfer, please provide the following information. Please respond individually with respect to each of the nine centers:

1. What criteria were used to select a Center for movement and how does each Center meet those criteria?

2. Where on the VAMC's property is the center to be located?

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

4. Where is the entrance to the Vet Center to be located?

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

5. What square footage will the Vet Center have in comparison to footage at its community setting?

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

B. What parking facilities will be available for staff and clients in comparison to those at its previous location?

6. What is the timetable for each of these proposed Vet Center relocations?

7. What are the costs associated with the move, individually and collectively?

8. What efforts were made in selecting each of the centers to determine the support for the move from among the Vietnam-era veterans in the various catchment areas and, at this point, do each of the proposed relocations enjoy general support among the veterans in their communities?

A. What views have the VAMC Director, Team Leader, and team members expressed about the move?

II. With regard to the Administrators' February 18 testimony, I have the following questions:

1. In response to my questions, the Administrator indicated that the Vet Centers in questions are to remain autonomous entities under the direct line authority of the Director, Readjustment Counseling Service, and further, that salary, staffing levels, and the provision of readjustment counseling services are to remain the same as they were prior to transition for at least 2 years. How have these various protections been incorporated formally in the transition activity? Please provide copies of any issuances setting forth these policies and any others relating to transition specifically or generally.

2. The Administrator also stated that our Committee would be notified prior to any decision being made to include any other Vet Center in any proposed move to the grounds of a VA facility. I would appreciate receiving assurances from you that any such notification will be provided at the earliest possible time in advance of any such proposed moves.

Thank you, John, for your ongoing cooperation and assistance. I look forward to receiving your reply to this letter at your earliest convenience. Please respond in numbered paragraphs corresponding to the numbered paragraphs of this letter.

With warm regards,

Cordially,

Alan Cranston
Chairman

Department of Medicine and Surgery
Washington DC [illegible]

Veterans Administration

JUN 1 8 1987

In Reply Refer To: 10B/RC

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in response to your inquiry of May 11, 1987, regarding plans to move nine Vet Centers from locations in community facilities to their support facilities. This letter also clarifies my testimony at the Committee's February 18 hearing relating to these centers.

The following criteria were used to select Vet Centers for relocation to support facilities: (1) Acceptability; (2) Catchment Area Distribution of Vietnam Era Veteran Population by Census; (3) Distance Between Vet Center and Medical Facility; (4) State Vietnam Era Veteran Outreach Centers; (5) Vietnam Veterans Resource Centers; (6) Special Population Factors; (7) Transportation and Parking; (8) Availability, Cost, and Suitability of Medical Facility Space; (9) Recurring Environmental Cost Comparisons; (10) Contract Program Impact; and (11) Actual Workload Trends at Present Vet Center. A review of the relocation sites selected indicates these criteria were met.

The remaining questions in Section I of your inquiry are responded to in another enclosure. With regard to questions 8 and 8A, Section I, all moves were discussed among the relevant community veterans' organizations, Vet Center Team Leaders, Directors of medical facilities, Regional Directors, Readjustment Counseling Regional Managers, and the Director, Readjustment Counseling Service. Although concerns were expressed by staff about possible problems at some sites, all such concerns are being addressed at this time.

I am also enclosing a copy of an information letter that provided guidance related to the transition, in response to Section II. You have my full assurance that your Committee will be advised in advance at the earliest possible time of any proposals to include other Vet Centers in plans for relocation to support facilities.

Your interest in this matter is appreciated.

Sincerely,

John A Gronvall

JOHN A. GRONVALL, M.D.
Chief Medical Director

Enclosures

"America is #1—Thanks to our Veterans"

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Avon, MA Vet Center

TO: Brockton, MA VAMC

2. Where on the VAMC's property is the center to be located?

Building #4--separate from main hospital.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

Geriatrics--second floor.

4. Where is the entrance to the Vet Center to be located?

Side of the building.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Over front door.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

None.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

2,500 (old) versus 2,800 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

7 (old) versus 9 (new)

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

Parking at both.

6. What is the timetable for this proposed Vet Center relocation?

9/30/87 implementation.

7. What are the costs associated with the move, individually and collectively?

$177,000

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Rochester, NY Vet Center

TO: Rochester, NY OPC

2. Where on the VAMC's property is the center to be located?

On second floor of Federal Building.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

Mental Hygiene Clinic.

4. Where is the entrance to the Vet Center to be located?

Front of Federal Building.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

In main lobby.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

None.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

1,000 (old) versus 1,800 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

3 (old) versus 7 (new)

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

Parking at the current community site is available, but there are no specific reserved parking spaces at the Federal Building where the VAOPC is located. Street parking is available on the usual first come, first served basis.

6. What is the timetable for this proposed Vet Center relocation?

6/27/87 implementation.

7. What are the costs associated with the move, individually and collectively?

$3,500

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Rochester, NY Vet Center

TO: Batavia, NY VAMC

2. Where on the VAMC's property is the center to be located?

Separate building on VAMC grounds.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

Proposed Mental Hygiene Clinic.

4. Where is the entrance to the Vet Center to be located?

Front and side entrance.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Over front door.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

None.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

1,500 (old) versus 1,800 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

6 (old) versus 7 (new)

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

Parking at both.

6. What is the timetable for this proposed Vet Center relocation?

10/1/87 implementation.

7. What are the costs associated with the move, individually and collectively?

$110,000

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Wilmington, DE Vet Center

TO: Wilmington, DE VAMC

2. Where on the VAMC's property is the center to be located?

Free-standing--former Medical Center Director's residence located at the rear of the VAMC/VARO grounds.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

No.

4. Where is the entrance to the Vet Center to be located?

Main entrance.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Signs from entrance of grounds to the door, including sign on Vet Center building.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

None.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

1,500 (old) versus 1,900 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

No noticeable difference.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

No noticeable difference.

6. What is the timetable for this proposed Vet Center relocation?

Completed 5/1/87. implementation.

7. What are the costs associated with the move, individually and collectively?

$26,500

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Fayetteville, NC Vet Center
TO: Fayetteville, NC VAMC

2. Where on the VAMC's property is the center to be located?

Co-located with the mental hygiene clinic in building #4, which is separate from the main hospital.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

Psychology, Psychiatry, and the Mental Hygiene Clinic.

4. Where is the entrance to the Vet Center to be located?

Side or rear entrance located in the middle of the building compared to the main entrance for Mental Hygiene patients.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Signs from entrance of grounds to the door, including sign at entrance of building.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

None if clients use the side and rear entrances; The Mental Hygiene Clinic if they use the main entrance.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

2,500 (old) versus 2,439 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

No noticeable difference.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

Once additional parking spaces are developed at VAMC, clients should be able to park within 100 feet of the building.

6. What is the timetable for this proposed Vet Center relocation?

7/1/87 implementation.

7. What are the costs associated with the move, individually and collectively?

$25,000

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Oak Park, IL Vet Center

TO: Hines, IL VAMC

2. Where on the VAMC's property is the center to be located?

Location will be in Building #1, which is used for outpatient services.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

All outpatient services are located in or slated to be in the same structure.

4. Where is the entrance to the Vet Center to be located?

Vet Center will have its own separate external entrance approximately 75 feet from the Mental Hygiene entrance.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Signs over the entrances to the hospital and the Vet Center will be erected; signs directing veterans to the Vet Center will be placed at appropriate locations within heavily trafficked areas.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

Depending upon where veteran enters, he/she could walk past multiple medical services or minimally the Mental Hygiene Clinic.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

2,400 (old) versus 2,310 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

The Vet Center will have staff offices, a reception/waiting area, and group activity room comparable to its former site.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

There are six parking spaces designated for clients outside of the new site. At the community location parking was not reserved, but ample and within easy reach of the Vet Center. Staff will park in the main hospital parking lot, which is less convenient but reasonable compared to their former parking arrangements.

6. What is the timetable for this proposed Vet Center relocation?

9/10/87 implementation.

7. What are the costs associated with the move, individually and collectively?

Renovation $80,983; equipment $4,000; and moving expenses $2,000. Total $86,983.

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Milwaukee, WI Vet Center

TO: Milwaukee, WI VAMC

2. Where on the VAMC's property is the center to be located?

Location will be in Building #5, which was formerly used as a men's domiciliary but is now unoccupied,

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

No other services are located in the same structure, nor are there any services slated to be co-located there.

4. Where is the entrance to the Vet Center to be located?

Vet Center will have a separate entrance which will remain exclusive even if additional services are to be located in the same structure.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Signs over the entrances to the hospital and the Vet Center will be erected; signs directing veterans to the Vet Center will be placed at appropriate locations within heavily trafficked areas.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

There are no other services in the same structure, but buildings in the immediate area contain VARO offices, library services, and recreational services.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

2,850 (old) versus 2,850 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

The Vet Center will have staff offices, a reception/waiting area, and group activity room comparable to its former site.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

Ten spaces have been designated for client parking at the hospital site in the DVB parking lot. This compares to ten available slots at the community site. Staff parking will be in employee parking located within 150 feet of the Vet Center. This represents a less convenient but reasonable difference over the community site.

6. What is the timetable for this proposed Vet Center relocation?

9/30/87 implementation.

7. What are the costs associated with the move, individually and collectively?

Renovation $86,000; equipment $5,000; and moving expenses $2,000. Total $93,000.

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Sioux Falls, SD Vet Center

TO: Sioux Falls, SD VAMC

2. Where on the VAMC's property is the center to be located?

The Vet Center is located on the second floor of Building #16, the Mental Hygiene Clinic. The building is located on the perimeter of the hospital grounds, separate from the main hospital structure.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

The Mental Hygiene Clinic is located on the first floor and there are no plans to relocate the clinic at this time.

4. Where is the entrance to the Vet Center to be located?

The Vet Center's entrance will be the front entrance to the building. Normally Mental Hygiene Clinic employees use the rear entrance.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

There will be two Vietnam Era Vet Center signs posted: one in front of the building facing the street and one by the rear entrance.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

None.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

1,775 (old) versus 1,806 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

The same number--four offices, group room, and reception area.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

Community location--street parking, five indoor parking and four outdoor adjacent to Vet Center. Hospital location--street parking and three outdoor spaces behind the building. Staff will park across from the building where the Vet Center is to be located, in a hospital parking lot.

6. What is the timetable for this proposed Vet Center relocation?

9/30/87 implementation.

7. What are the costs associated with the move, individually and collectively?

Renovation $34,000 and moving expense $800.

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Houston, TX Vet Center

TO: Houston, TX VAMC

2. Where on the VAMC's property is the center to be located?

Initial site will be in former Medical Ward 115, Building #105, attached to the main VAMC, away from the Mental Hygiene Clinic.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

Quality Assurance Department will be located in the same structure as the Vet Center.

4. Where is the entrance to the Vet Center to be located?

Accessibility to the Vet Center is available through a street entrance as well as a hallway.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

Signs will be posted on the door of the main VAMC entrance directing veterans to the Vet Center location.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

Veterans would not walk through any other service if using the street-side entrance. If using the hallway entrance, veterans would walk through the Quality Assurance Department.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

Initially, the Vet Center will lose about 500 square feet of usable space . However, long term plans indicate that comparable space will be made available through subsequent move.

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

The community location has seven offices, one group room, one waiting room, and a lobby. The VAMC location will have seven offices, two group rooms, and a waiting room.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

The Vet Center has a parking lot and street-side parking at its current location. At the VAMC facility, six parking spaces have been designated as Vet Center space. General VAMC parking is available nearby for use of vet center clients.

6. What is the timetable for this proposed Vet Center relocation?

7/16/87 implementation.

7. What are the costs associated with the move, individually and collectively?

Telephones $806; renovation/furnishings $5,000; relocation $1,500; and utilities $200. Total non-recurring $7,506.

RESPONSE TO SENATOR CRANSTON'S QUESTIONS 2 THROUGH 7

RELOCATION FROM: Northridge, CA Vet Center
TO: Sepulveda, CA VAMC

2. Where on the VAMC's property is the center to be located?

The Northridge Vet Center will be located outside the VAMC proper at a residential site owned by the VA at 16126 Lassen Street, Sepulveda, California 91343.

3. Are there any other services (VA or otherwise) located in, or slated to be located in, the same structure into which the Vet Center is being moved?

There will be no other services (VA or otherwise) located in or slated for the same structure into which the Vet Center is moving.

4. Where is the entrance to the Vet Center to be located?

The entrance to the Vet Center is on the side of the structure off the parking lot.

A. What signs will be posted, and where, regarding the Vet Center's presence and location?

A "Vet Center" sign will be placed near the street for high visibility.

B. What other services or activities would a veteran walk past in the building in order to reach the Vet Center?

Veterans will have to pass no other services or activities in order to reach the Vet Center.

5. What square footage will the Vet Center have in comparison to footage at its community setting?

2,750 (old) versus 1,394 (new)

A. How many offices and meeting and commons rooms will it have in comparison to those at its community location?

The current site contains four offices, one meeting room, and one common room. The proposed site contains three offices, one meeting room, and one common room.

B. What parking facilities will be available for staff and clients in comparison to those at its community location?

The current location shares a parking lot with a small business. The proposed site will have a larger parking lot exclusively for the use of the Vet Center.

6. What is the timetable for this proposed Vet Center relocation?

7/3/87 implementation.

7. What are the costs associated with the move, individually and collectively?

The estimated cost of moving the current tenant is $970, with no other personnel costs.

TELEGRAPHIC MESSAGE

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ACCOUNTING CLASSIFICATION	DATE PREPARED 2/10/87	FILE
FOR INFORMATION CALL		
NAME SUSANNE R. MILLER	PHONE NUMBER 373-2409	TYPE OF MESSAGE ☐ SINGLE ☒ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:
DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT
CLINICS (REGIONAL DIRECTORS)

(00)/DIRECTOR FOR OPERATIONS' LETTER, IL 10B-87-5

(DTD: 2/24/87)

SUBJ: DIRECTOR FOR OPERATIONS' WEEKLY INFORMATION LETTER

THIS NEWSLETTER INCLUDES A SUMMARY OF PERTINENT INFORMATION FROM THE JANUARY 16 AND 30, 1987 DIRECTOR FOR OPERATIONS' CONFERENCE CALLS.

1. MERITORIOUS EXECUTIVE - PRESIDENTIAL RANK AWARD: ON JANUARY 28, 1987, THOMAS P. MULLON WAS PRESENTED THE 1986 PRESIDENTIAL RANK AWARD FOR MERITORIOUS EXECUTIVE. THIS AWARD IS GIVEN FOR SUSTAINED ACCOMPLISHMENTS OVER A MINIMUM 3 YEAR PERIOD AS A SENIOR EXECUTIVE OR EQUIVALENT AND INCLUDES A MONETARY AWARD IN THE AMOUNT OF $10,000. NOMINEES ARE ASSESSED BASED ON THEIR CAREER ACHIEVEMENTS, COST REDUCTIONS, ACHIEVEMENT OF EEO GOALS, SUCCESSFUL USE OF HUMAN RESOURCES, AND PERSONAL INITIATIVE AND INNOVATION. AMONG TOM'S ACCOMPLISHMENTS THAT HAVE BEEN

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MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

11. RE VET CENTER RELOCATION PLANNING: SECTION 612A OF TITLE 38 CALLS FOR THE RELOCATION OF SOME VET CENTERS (WHICH WE UNDERSTAND TO MEAN A MAJORITY) TO MEDICAL FACILITIES DURING FISCAL YEARS 1988 AND 1989. THE LAW SPECIFIES NO OTHER CHANGES.

THE DM&S VET CENTER PLANNING COMMITTEE REVIEWED THE PROGRAM'S OPERATIONS AND DEVELOPMENT FROM 1983 TO 1986. IN 1986, THE COMMITTEE MADE A NUMBER OF RECOMMENDATIONS, WHICH WERE SUBSEQUENTLY APPROVED BY THE CHIEF MEDICAL DIRECTOR. THESE CALL FOR (1) CONTINUING THE PRESENT VET CENTER ORGANIZATION STRUCTURE WITH NO MAJOR ALTERATIONS, WHILE ACHIEVING OPTIMAL FUNCTIONAL COLLABORATION WITH VA MEDICAL FACILITIES AT ALL LOCATIONS; (2) GRADUAL REDUCTION IN PROGRAM SIZE IN FUTURE YEARS (FY 1989 AND AFTER) IN RESPONSE TO EXPECTED DECREASED NEED, AND (3) A DEPARTMENTAL REQUEST FOR A LEGISLATIVE INITIATIVE TO ALLOW DM&S TO PROVIDE READJUSTMENT COUNSELING IN FUTURE YEARS IN A MANNER TO BE DETERMINED BY THE AGENCY. IT IS IMPORTANT

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MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

TO NOTE THAT IN 1983 THE CONGRESS REMOVED ANY DELIMITING DATE FOR ELIGIBILITY FOR READJUSTMENT COUNSELING ON THE PART OF VIETNAM ERA VETERANS. THEREFORE, FOR PLANNING PURPOSES, SUCH ELIGIBILITY IS PERMANENT.

THE CURRENT AGENCY OUT-YEAR BUDGET PROJECTION, SUBJECT TO RE-EVALUATION WHEN THE DEPARTMENTAL FY 1989 BUDGET REQUEST IS INITIATED, CALLS FOR THE SAME READJUSTMENT COUNSELING BUDGET IN FY 1988 AS IN 1987, AND THEN A TEN PERCENT REDUCTION IN DOLLARS PER YEAR COMMENCING IN FY 1989.

THE LAW REQUIRES THAT BY APRIL 1, 1987, THE ADMINISTRATOR WILL REPORT TO CONGRESS, PROVIDING AN EVALUATION OF THE EFFECTIVENESS OF THE READJUSTMENT COUNSELING PROGRAM IN MEETING THE NEEDS OF VETERANS, AN ASSESSMENT OF THE EXTENT TO WHICH VIETNAM ERA VETERANS' NEED FOR READJUSTMENT COUNSELING REMAIN UNMET, THE EXTENT TO WHICH COMMUNITY-BASED VET CENTERS ARE REQUIRED TO MEET SUCH NEEDS, AND ANY OTHER RECOMMENDATIONS, INCLUDING LEGISLATIVE AMENDMENTS, THE ADMINISTRATOR WISHES TO MAKE.

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MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

IN LIGHT OF THE FOREGOING, AND KEEPING IN MIND THE POTENTIAL FOR NEW DEVELOPMENTS IN CONNECTION WITH THE ADMINISTRATOR'S APRIL 1987 REPORT TO CONGRESS ON THE PROGRAM, AND THE EXPECTED REVIEW AND RE-EVALUATION OF THE PROGRAM BY THE NEW CONGRESS, AT THE PRESENT TIME DM&S PLANS THE FOLLOWING:

- o AS A PILOT PROJECT, MOVE SEVERAL VET CENTERS TO MEDICAL FACILITY GROUNDS DURING THIS FISCAL YEAR.
- o IF PRESENT LANGUAGE OF SECTION 612A REMAINS IN EFFECT, MOVE ADDITIONAL VET CENTERS, TOTALING A MAJORITY, TO MEDICAL FACILITIES DURING FISCAL YEARS 1988 AND 1989.

CRITERIA HAVE BEEN DEVELOPED FOR SELECTION OF WHICH VET CENTERS WOULD MOVE TO MEDICAL FACILITIES, AND SPACE ANALYSES AND REQUIREMENTS ARE TO BE DEVELOPED IN DUE COURSE. CONTACT PERSON: ARTHUR S. BLANK, JR., M.D. (10B/RC), FTS 373-3317.

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GAO Report on Readjustment Counseling Program.—The General Accounting Office recently released a report—"VIETNAM VETERANS: A Profile of VA's Readjustment Counseling Program", GAO/HRD-87-63—which was in response to a November 1, 1984, request from the then-Chairman of the Committee, Senator Alan K. Simpson, for a comprehensive review of the Readjustment Counseling Program.

The GAO's overall evaluation of the program was generally positive. In response to one specific charge—to evaluate the need for retaining vet centers in community-based locations—the GAO recommended that the "VA should be able to decide on a case-by-case basis whether vet centers should be relocated to existing VA facilities . . . and the Congress should consider enacting legislation to permit the VA to do so." In support of this recommendation, GAO noted that there were "no compelling reasons, concerning the cost or quality of counseling services or veterans' access to them, for the VA to be required [as under current law] to provide [counseling] services through existing VA facilities."

The VA, in a June 11, 1987, letter in response to a draft version of this report, which is included in the GAO report, endorsed the GAO's recommendation that the agency be permitted to make decisions regarding the relocation of vet centers on "a case-by-case basis", noting that that approach would "permit the Agency to consider each center's changing needs and the method and location best suited to meeting those needs."

Committee bill

It is in light of the experience with the proposed relocation of the 9 centers, this Administration's historic hostility to the program, and the recent GAO report that the Committee has come to the view that there should be no fixed formula requiring such relocations on a wholesale basis, as under present law. The Committee bill reflects the view that the current-law transition requirement is today an anachronism—enacted for a protective not a destructive purpose—that will lead to arbitrary decisions and to poor public policy results.

Despite the Committee's success last year, in Public Law 99-576, in making the transition period a gradual, 2-year process, current law contains no express restriction on any closures of vet centers during the transition period. Rather, it requires that more than half of whatever number of vet centers exist at the end of the transition be operated at general VA facilities. Based on the information currently available including a 3.4-percent increase in new clients and a 3.2-percent increase in visits at vet centers for the first 10 months of FY 1987 as compared to a year ago, the Committee has concluded that the policy reflected in current law is seriously flawed and should be repealed.

The Committee bill would do just that and substitute an approach designed to ensure that decisions regarding the Readjustment Counseling Program and individual vet centers are made carefully, and in accordance with the best professional judgments available, on a case-by-case basis in accordance with objective criteria derived directly from the VA's own published criteria.

Summary of provisions.—Specifically, title III of the Committee bill would:

First, eliminate the statutory requirement for a fixed transition of vet centers.

Second, replace that transition provision with one permitting a closure or relocation of a vet center only upon a determination by the VA's Chief Medical Director, based on the application of certain criteria (described below), that such a closure or move would not result in any diminution in the continuing availability and effective furnishing of readjustment counseling needed by veterans entitled to such services in the geographic area.

Third, require that 60 days' advance notification and detailed information be submitted to the two Veterans' Affairs Committees before any such closure or relocation is carried out.

Fourth, with respect to substantial Readjustment Counseling Program reorganizations, permit in any fiscal year the closure or relocation of more than 10 percent of the vet centers in existence on July 1, 1987 (189) to proceed only if proposed at the time of the President's budget submission for the year in which they would occur, approximately 8 months before that fiscal year begins on October 1 (the same type of process that currently applies in the case of administrative reorganizations at other VA facilities that involve certain employee reductions of 10 percent or more of the full-time equivalent employees at such facilities in any fiscal year). Thus, up to 18 vet centers per fiscal year could be moved or relocated without recourse to this notify-and-wait process.

Fifth, protect for 2 full fiscal years the budget and personnel ceiling for any relocated vet center, with authority granted to the Chief Medical Director to reduce funding or staffing or both after the first year upon finding a real reduction in the Center's workload.

Sixth, make veterans who served since the end of the Vietnam era in combat conditions entitled to readjustment counseling services.

Seventh, make World War II and Korean-conflict veterans and active-duty personnel who served either during the Vietnam era or since then in combat conditions eligible for, although not entitled to, readjustment counseling services.

Eighth, explicity authorize the relocation to vet centers of other VA personnel from the Department of Veterans Benefits and elsewhere in the Department of Medicine and Surgery for the purpose of providing veterans with other VA benefits and services at vet centers.

Ninth, require that all vet center personnel who have served satisfactorily for 2 years be converted to career positions beginning 90 days after the enactment date of this measure.

Notice prior to any closure or relocation.—In order that the two Veterans' Affairs Committees may effectively monitor and evaluate any planned vet center relocation or closure, the Committee bill would require notice at least 60 days prior to the execution of any such proposed action. Such notification would be required to include a description of the results of the consideration given to the criteria specified in the bill in terms of the selection of the particular vet center for closing or relocation.

Criteria to be considered.—The specified criteria—each of which is derived from the criteria developed by the VA as described in Dr. Gronvall's June 18 letter, which appears above, and set forth as part of the Administrator's April 1/July 9 and July 1/August 3 reports—require consideration of:

1. The distribution of Vietnam-era veterans in th geographic area served by the existing vet center and the relationship between the location of the Vet Center and the medical or other facility (hereinafter referred to as the "receiving facility") where readjustment counseling services would be furnished if the vet center were closed or relocated and such distribution of Vietnam-era veterans so as to evaluate the likely impact of any relocation of veterans' receipt of services.

2. The distance between the existing vet center and the receiving facility so as to evaluate whether any hardship would be imposed on veterans currently being furnished services at the Vet Center if they would have to travel to the receiving facility to receive services.

3. The acceptability of the proposed closure or move to various groups that would be affected by such an action, including the staff of both the existing vet center and the receiving facility, representatives of veterans' service organization located in the geographic area served by the existing vet center, and individual veterans who are being furnished services at the existing vet center, so as to determine if a positive attitude toward the proposed action exists, thereby enhancing the likelihood of its success, without according to any particular group or all the groups a veto over the proposed action.

4. The availability of other entities, such as State, local, or private outreach facilities, which provide assistance to Vietnam-era veterans in the area served by the existing vet center, so as to evaluate whether any need for services in the immediate geographic area of the vet center could be met by other entities.

5. The availability of transportation to, and parking at, the existing vet center and the receiving facility.

6. The availability, cost, and suitability of the space at the receiving facility, including the opportunity to establish a direct entry into the area where readjustment counseling services would be furnished and the suitability of the environment—including the VA services located nearby—where such services would be furnished so as to avoid locations (such as in the vicinity of mental health programs) that would be counterproductive to the furnishing of such services and to promote locations (preferably separate buildings) where a vet center identity could best be maintained.

7. In the case of a relocation, a comparison of the recurring nonpersonnel costs at the existing vet center and the receiving facility, so as to determine the cost-effectiveness of the proposed action.

8. The impact of the proposed closure or relocation on the program for furnishing eligible veterans readjustment counseling services through private facilities under a vet center-administered contract, so as to determine if the contract program would have to be increased as a result of the closure or relocation of the vet center.

9. The workload trends over the prior 2 fiscal years at the existing vet center, so as to determine the cost-effectiveness of a proposed relocation.

In addition to these criteria, the Chief Medical Director would be given authority to consider other factors as long as they relate to the effective provision of readjustment counseling services.

Information relating to each of these factors should enable the VA and the Committees to evaluate fairly any proposed closure or relocation.

Additional advance-notice requirements for major changes.—In order to ensure that any changes in the character of the Readjustment Counseling Program are carried out in a gradual, orderly manner (as is currently required by law to occur during the FY 1988-89 transition period), the Committee bill would prohibit, in any fiscal year after FY 1988, the relocation or closure of vet centers involving more than 10 percent of those in existence on July 1, 1987—18 centers in total—unless such a change were proposed at the time of the President's budget submission, 8 months prior to the start of the new fiscal year in which such a change would occur. In FY 1988, the limitation would apply to any relocation or closure involving 5 percent of the vet centers in existence on July 1, 1987—or a total of 9 centers.

This limitation should give the VA significant flexibility to take actions to close or relocate some centers while retaining protection in the case of major reorganizations affecting the overall Readjustment Counseling Program.

Protection of personnel ceiling and budget.—To ensure the integrity of the budgetary and personnel ceilings of the readjustment Counseling Program and thereby guarantee the quality of services being provided to veterans utilizing the services of vet centers, the Committee bill would generally protect for 2 full fiscal years the budget and personnel ceiling of any vet center relocated to a VA general facility. However, the Chief Medical Director would be given the authority to reduce funding or staffing or both after the first full fiscal year based on a determination that there has been a real reduction in a vet center's workload, that is, a reduction in the need for the services in the geographic area concerned without regard to any reduction in demand stemming from the original relocation. In making this determination, the CMD would be required specifically to determine whether a move away from the VA general facility—either back to the vet center's prior location or to another location in the community—would be highly unlikely to result in a workload sufficient to justify the existing funding and staffing levels. The Committee believes that such protection is vital if a relocated facility is to continue to furnish the services needed by those veterans who are seeking assistance. In this regard, the Committee notes that Administrator Turnage, in response to a question from Chairman Cranston at the Committee's February 18 hearing on the VA's FY 1988 budget, agreed to provide similar such protection of vet center staff and funding.

Extension of readjustment counseling eligibility.—The Committee bill would make three changes in the statutory eligibility for readjustment counseling under current section 612A of title 38. First, the bill would extend readjustment counseling entitlement to veterans of service in hostilities after May 7, 1975, the end of the Vietnam era. Under this change, the Administrator, after consultation with the Secretary of Defense, would determine that service during specific periods of time in specific locations in which U.S. Armed Forces were under hostile fire would be qualifying service for readjustment counseling purposes. This provision recognizes that members of our Armed Forces are at times exposed to combat situations short of declared war—such as existed in Beirut or Grenada or in connection with our actions against Libya, or that existed most recently during the incident that occured with the USS Stark and in connection with Navy efforts in conjunction with the reflagging of Kuwaiti tankers in the Persian Gulf, or that possibly exist today in Central America. These situations well might produce the need among those involved in them for readjustment counseling to help deal with the psychological aftermath of the experiences.

The Committee stresses that this authority, if enacted, should be used only in very limited circumstances in which our service personnel actually experienced combat situations.

A second proposed change in eligibility relates to individuals who served during the Vietnam era but who are still on active duty and, thus, are not at present considered "veterans" under the applicable definition in section 101(2) of title 38, United States Code. Under provisions in the Committee bill, which are derived from provisions in S. 6, introduced by Chairman Cranston on January 6, these individuals would be made eligible for—but, in a change from the bill as introduced and as distinguished from Vietnam-era veterans, not entitled to—readjustment counseling. The same eligibility—also changed from entitlement as proposed in the bill as introduced—would be extended to those still on active duty who served in the types of combat situations described above since the end of the Vietnam era.

Although the Committee is not aware of any data suggesting a widespread unmet need for counseling among active-duty personnel who served in Vietnam or in combat situation since then, it is also not aware of any study having been made regarding such needs. Considerable anecdotal information has been received by the Committee of such active-duty personnel having requested counseling at vet centers, and of informal efforts at some vet centers to provide services to active-duty personnel despite a lack of express authority to do so. The Committee does not believe that any individual who served in the Armed Forces during the Vietnam era or in a combat situation since then and feels a need for readjustment counseling should be barred from eligibility simply because he or she is still on active duty. The Committee bill would provide the VA with authority to furnish the necessary counseling.

With further reference to this issue, the Committee notes the August 7, 1987, letter from Secretary of Defense Casper Weinberger (reprinted in the "Agency Reports" section of this report) which expressed the opposition of the Department of Defense to the extension of eligibility for readjustment counseling to active-duty personnal. In expressing DOD's opposition, Secretary Weinberger made the point that military health care openly plays the role of weeding out personnel on health grounds. The Committee is concerned that it is exactly this practice that could discourage active-duty members from seeking assistance that might be needed to help them overcome psychological problems related to their combat service and thus enhance their effective functioning during service as well as thereafter.

The VA, in its testimony at the Committee's May 21 hearing, expressed the view that such services should be furnished under a sharing agreement with the Department of Defense pursuant to Public Law 97-174. However, in response to a question from Chairman Cranston, the VA indicated that only one such sharing agreement between VA and DOD exists at present. Further, the VA agreed with the point made by The American Legion that it is unlikely that such sharing agreements would work because many career personnel would not seek readjustment counseling for fear of jeopardizing their advancement because of receiving "what could be construed as psychiatric treatment". The VA, in response to a question from Chairman Cranston, noted that it "is likely that anonymity would be an important matter for active duty career personnel who contemplate any form of psychological counseling or mental health services." Thus, it does not appear likely that sharing agreements would be a useful or appropriate approach in this area.

Third, the Committee bill includes provisions pursuant to which veterans of World War II and the Korean conflict, with a particular emphasis on those who were in combat with the enemy, would also be made eligible for—but, in a change from the legislation as introduced, not entitled to—counseling through the Readjustment Counseling Program if they requested it. In the Committee's view, the Federal Government should never allow to go unmet the requests for counseling help from those who have experienced the stress of combat while serving in the Armed Forces.

With reference to this issue of meeting the needs of veterans of prior wars, the Committee notes the testimony at an April 30, 1981, Committee hearing of Dr. Arthur Arnold, then the Chief of Psychiatry at the Bay Pines, Florida, VA Medical Center and now the Chief of Psychiatry at the Phoenix VAMC, about a World War II veteran he was treating for alcoholism. Dr. Arnold described the case as follows:

> There was a man in his late 50's who had been treated in VA hospitals for probably 30 admissions for alcoholism over the last 40 years who finally because of the growing awareness of the staff of the importance of knowing the war experience, was asked what he had done in World War II.
>
> Finally, it came out that he has had nightmares for 40 years of being under fire pinned down on a beach in the South Pacific for 72 hours as a teenage corpsman trying to patch pieces of bodies together. This had never come out . . . until now, so the man had never really gotten treatment that went to the core of his problems.

It seems clear that that veteran was suffering from problems related to his combalt experience and needed assistance which recognized that fact.

In a similar vein is an article by Marlene Cimmons in the August 15, 1985, Los Angeles Times, headlined "Stress Problems Show Up Among Veterans of WWII", which describes war-related problems among WWII veterans. This article was printed in the Congressional Record by Chairman Cranston on July 15, 1987, at S10068–69.

Authorizing the provision of additional VA services.—Certain services, other than readjustment counseling services, provided by the Department of Veterans Benefits (DVB) (such as assistance in applying for compensation, education, or vocational rehabilitation benefits) and the Department on Medicine and Surgery (DM&S) (such as furnishing drug and alcohol counseling, screening for other health problems, or preventive health services) can be and, in some instances already are, appropriately and effectively provided at vet center locations by DVB and DM&S staff. The vet center provides an excellent setting for the provision of various VA services to veterans who might not otherwise be reached at traditional VA facilities, and the Committee bill would provide express authority and sanction for such services to be provided at vet centers and for the Administrator to assign personnel to vet centers to provide such services. The Committee notes that it is not its intent that any additional personnel or other resources would be added to support this new authority. Rather, the Committee expects that, under this discretionary authority, currently employed personnel would be reassigned to vet centers on a full- or part-time basis if it were determined that they could cost-effectively be utilized to provide their services in those settings.

In this regard, the Committee notes that the VA in recent years has been supporting various new initiatives that involve greater VA cooperation with community entities so as to meet the health-care needs of eligible veterans in community settings. Among such initiatives are the VA's program of half-way-house contract care for veterans with drug or alcohol abuse dependencies, the newly implemented community-based treatment of homeless veterans with chronic mental illness disabilities, and the agency's adult-day-health-care program. The Committee believes that requiring the Vet Center Program, which has been so successful in community locations, to undergo a wholesale shift to a more in-house program would be counter to this successful trend in other VA health-care settings and that consideration should thus be given to moving appropriate other VA services to the community settings in which vet centers function.

Career conversion of certain vet center personnel.—At some vet centers, certain staff members who have been with the Readjustment Counseling Program for an extended period of time continue to work under time-limited appointments and have not yet received career status within the Federal Civil Service system.

This issue of program personnel being employed on time-limited appointments has been a matter of concern to Committee members for some time. On October 29, 1986, Chairman Cranston wrote to Dr. John Gronvall, the then-Acting Chief Medical Director of the VA, regarding this issue. Dr. Gronvall, in a December 4 letter, indicated that an effort was underway to convert personnel to career status. This exchanged of correspondence is printed below.

Although the Committee is pleased that such an effort has been made by the agency, it is very concerned that it is neither as complete nor as timely as it should be.

In the Committee's view, any individual who has been with the program for at least 2 years and who, in that time, has performed in a satisfactory manner should be given career status. Thus, the Committee bill would require, beginning 90 days after the date of the enactment of this measure, that all Readjustment Counseling Program personnel who have served in a satisfactory manner for a such a period of time be promptly converted to career positions. Those who have so served as of the ninetieth day after the enactment date of this bill, must be converted within 120 days after the enactment date, and others must be converted within 30 days after reaching the 2-year mark.

With further reference to the conversion of these employees, the Committee notes that the 2-year service period in the Committee bill is a maximum and does not perclude action to convert an employee to career status at any earlier point if the agency considers such action appropriate.

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN

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ANTHONY J. PRINCIPI, CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R. STEINBERG, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

October 29, 1986

Dr. John A. Gronvall
Acting Chief Medical Director
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear John,

I have been concerned for a number years about the fact that many of the individuals who are employed by the Veterans' Administration in the readjustment counseling program were not hired into career civil service positions but rather were given temporary appointments. Many of the program's employees have indicated to me that this situation has created morale problems both because those employed under temporary appointments have no current job security and also because they are unable to make plans for the future when their services may no longer be needed within the readjustment counseling program.

When I raised this issue with then-Chief Medical Director Dr. Donald Custis in 1983, Dr. Custis indicated in an April 5, 1983, letter (a copy is enclosed for your ready reference) that, at that time, only 27 percent of the employees in the readjustment counseling program were career employees. He also indicated that the issue of the retention in the VA of all or part of this group of employees was being considered by the readjustment counseling Task Force.

It is my understanding that the Task Force, after studying this issue, made the following recommendations in 1984 for action by DM&S regarding the conversion issue:

- Institute conversion criteria to convert those employees then-eligible.
- Assist in the establishment of eligibility on Civil Service Registers for those not then-eligible.
- Explore the feasibility of OPM authorizing the non-competitive conversions of those persons who cannot establish eligibility.

It is my further understanding that these recommendations were approved by Dr. Custis.

I do not understand why this issue continues to be a festering sore in the readjustment counseling program fully 2 years after the Task Force made its recommendations. With the approach of the onset of the now 2-year transition period on October 1, 1987, I believe that it is absolutely vital that the recommendations be implemented immediately, absolutely vital that the recommendations be implemented immediately, fully, and aggressively and that each readjustment counseling program employee without career status be given individual advice and assistance with respect to that employee's career opportunity possibilities and that thereafter appropriate followup take place to assist each employee with potential convertability.

Hence, I would greatly appreciate learning the current status of this issue. In addition to your response to the concerns I expressed in the preceding paragraph, I am interested in receiving your answers to the following questions:

(1) Were the Task Force recommendations listed above approved by Dr. Custis?

(2) If so, what has been done to implement them?

(3) A. Are those recommendations DM&S policy objectives today?
B. If not, why not?

(4) What is the breakdown, by job title and by readjustment counseling program region, of current employees as between those who have career civil service appointments and those who are serving in a temporary status?

(5) What is the goal of DM&S for converting those on a temporary status and what is the timetable for the achievement of that goal?

Thank you for your continuing cooperation and assistance.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

Enclosure

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

APR - 7 REC'D

APR 5 1983

In Reply Refer To: 11RC

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for your letter of February 22, 1983, wherein you raised some additional questions relative to the fee-for-service component of the Readjustment Counseling Program. I will respond to the questions you have raised following a paraphrasing of those questions.

1. What will be the total dollar amount expended for FY 1983? If not available now, why not: when will it be available?

> A nationwide fee-for-service program was initiated by the Readjustment Counseling Service in April 1982. Over 400 contracts have now been let to private providers and approximately 6,000 veterans have been referred. It is our opinion that seven to eight million dollars of the $11.2 million earmarked for the fee-service program will be used during fiscal year 1983.

2. What is the reason for the requirement of 50% membership of Vietnam Theater veterans in group sessions? Why is this appropriate for Vietnam "Era" veterans? How is "Vietnam Theater" authenticated?

> Professional experience has demonstrated that "Theater" veterans are most benefited by group counseling with other "Theater" veterans, at least in minimum number (peer counseling). For a non-theater, era veteran, this limitation would not be relevant, and thus it was modified. If a veteran served on active duty during the period August 5, 1964 to May 7, 1975 and was stationed with U.S. armed services in Vietnam, Laos, Cambodia, or on ships or aircraft within a combat zone, it is assumed that the veteran served in the "Vietnam Theater." An alternate expression of the same definition is that the veteran received combat pay.
>
> The "50% rule," as outlined in our November 30, 1982 TWX was modified by a TWX (copy enclosed) prepared February 15, 1983. Our field stations were sent copies of this telegraphic message in early March.

2.

3. What guidance has been provided to the field relating to the inability on the part of an individual veteran to receive counseling from a Vet Center?

> There may be, as you have pointed out in this question, times when extenuating circumstances require referral of a client for fee-service counseling because the client may feel significant hostility to Federal or VA employees (including Vet Center staff). A verbatim copy of the technical ammendment as outlined in Senate Report No 96-195, is being sent to our Regional Coordinators who will notify our Team Leaders of this congressional intent.

4. What guidance is provided to Vet Centers and contractors regarding the level of mental health services authorized and how is compliance with that guidance monitored?

> This question seems to refer to the matter of sophistication, complexity, and intensiveness of counseling and psychotherapy. Vet Centers, VAMCs, and contract providers all vary according to the "level" of services. This is often dependent on the particular service providers involved, especially as concerns their professional skills and experience. As such, this is not a matter for VACO guidance. Rather, Vet Center, VAMC, and contractor staff form their best professional judgements (with local or regional supervision) about the "level" of services they are qualified to provide.

5. How is commercial advertising defined when referring to restrictions placed upon contractors and would this restriction apply to contractors' brochures?

> It is our judgement that providers could distribute privately or in some way make available, a brochure describing the services they offer, as opposed to "commercial advertising," which is defined as "paid promotional announcements to the public."

6. What percentage of team leaders and counseling staff are: Vietnam veterans, Vietnam era veterans, career civil servants, and temporary status employees? What plans are made for employment opportunities for those in temporary status?

Vietnam Veterans........	54%	
Vietnam Era Veterans....	21%	(Does not include Vietnam Veterans)
Career employees........	27%	
Temporary status........	73%	

3.

Plans relative to the retention in the VA of all or part of the currently temporary employees is an issue that is now under consideration by the Readjustment Counseling Task Force.

7. Who are the members of the Readjustment Counseling Task Force?

Thomas Mullon, Regional Director Midwestern Region, Chairman
Arthur Blank, Jr., M.D., Director Readjustment Counseling Service, Co-Chairman
Robert Coy, Deputy General Counsel
John Fulton, M.S.W., Director Social Work Service
Alan Glaser, Executive Assistant to the Associate Deputy Chief Medical Director
Gene Hufford, Special Assistant to the CMD for Regulations Policy Review
Stephen Lemons, Ed. D., Director, Vocational Rehabilitation and Counseling Service (D.V.B.)
Arthur Lewis, M.D., Deputy Assistant Chief Medical Director for Professional Services
John Lipkin, M.D., Associate Director for Psychiatry, Mental Health and Behavioral Sciences Service
Gustavo Martinez, M.S.W., Assistant Director for Program Management, Readjustment Counseling
Shad Meshad, M.S.W., Readjustment Counseling Regional Coordinator, Western Region.

What is the specific charge to the task force, its timetable, and how does this relate to the legislated report required of the Administrator?

The charge to the Planning Task Force is as follows:

To prepare detailed plans for a phase-in of the Readjustment Counseling Program from a program providing services primarily through Vet Centers to a program providing services primarily within VA medical facilities, as provided for in current legislation, taking into account all relevant Vietnam Era veteran service needs and existing VA medical facility service structures and required changes in such structures. The Task Force will also develop recommendations relating to the continuation of current services considered essential for the target population before the phase-in period begins. Considerations should include establishment of measures to ascertain needed services; options and methods of providing these essential services; and a phasing schedule. The Task Force should also review and make recommendations about program evaluation which may be desirable in this area. Finally, this Task Force is to consider and make recommendations concerning both professional (especially training) problems and administrative issues, such as personnel and budget, in the evolution of the Readjustment Counseling Program.

The Task Force is scheduled to provide a final report in the Fall of 1983.

The report of the Planning Task Force will provide substantial information on which decisions will be based and these will have a major impact on the report the Administrator is mandated to submit by Section 612A (g) (2) of Title 38, United States Code.

I appreciate your continued interest in the veterans of the country.

Sincerely,

(F) DONALD L. CUSTIS, M.D.
Chief Medical Director

Enclosure

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

[illegible]

DEC [illegible] 1986

In Reply Refer To: 10B/RC

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for your letter of October 29, 1986, concerning career appointment status of personnel in the Readjustment Counseling Program (Vet Centers).

The recommendations made by the Vet Center Planning Committee (formerly Readjustment Counseling Planning Task Force) referred to in your letter had been approved by the Chief Medical Director in 1984. These recommendations are current policy objectives of the Department of Medicine and Surgery.

In order to implement the goal of converting Vet Center personnel to career status, the Agency has established regular job series for readjustment counselors, and implemented pre-existing job series where applicable, such as for social workers, psychologists, and clerical staff.

Conversions of personnel to career status have thus been proceeding subject to certain constraints. Only 55 of 220 additional FTE supplied to the Agency for the program expansion authorized in 1984 may be occupied with persons on career appointment, due to a Congressionally-imposed limitation. Usually, employees are not recommended for conversion to career status until they have been employed in a Vet Center for at least 12 months. In addition, performance is taken into account by program management in recommending conversion.

Within these constraints, the Agency has been proceeding with conversion of personnel to career status. During the 13-month period, October 1, 1985, through October 31, 1986, 110 employees were converted to career status. As a result of this initiative, of 794.9 FTE in the program, a total of 363.7 FTE are now holding career status, or 46 percent. This is to be compared with the figure of 27 percent as of April 1983. In further implementation of the policy objectives, 38 employees who are GS-10 and below, and 94 employees who are GS-11 and above, are now being reviewed for authorization for conversion, in VA Central Office. I expect that most of this group will receive career appointments by March 31, 1987.

Beyond that group of employees, we will continue, subject to the constraints indicated above, the ongoing process of accomplishing the objective set by the Chief Medical Director in 1984.

The additional data which you have requested by way of a breakdown by job, title, and region of employees in the career and non-career categories, are now being assembled in the field and will be furnished to you by December 15, 1986.

I appreciate the opportunity to provide this information.

Sincerely,

John A. Gronvall

JOHN A. GRONVALL, M.D.
Acting Chief Medical Director

Changes in S. 1501 as introduced.—Prior to the Committee's July 31 meeting, there was an attempt to develop a compromise on the provisions relating to the Readjustment Counseling Program, as proposed in S. 1501 as introduced and amended by Amendment No. 610, that would be acceptable to most if not all of the members of the Committee. Although that compromise ultimately was not agreed to, most of the revisions developed during that effort were proposed by the Chairman and included in the Committee bill in order to narrow the differences and to demonstrate the good faith that had characterized the attempt to reach a consensus. These revisions are as follows:

—The provision in S. 1501 to make any action which resulted in the relocation of 25 personnel in the Readjustment Counseling Program an administrative reorganization that could only proceed with at least 8 months advance notice, was modified to raise the threshold for such a "notify and wait" requirement to any action after FY 1988 involving the movement or closure of 18 vet centers—9 in FY 1988—thereby providing significantly more flexibility for the VA to take actions to move or close up to this many centers without such a long waiting period while still retaining protection in the case of major reorganizations affecting the program.

—The provision in S. 1501 that would have protected the budget and staff of any vet center moved to a VA medical center for 3 full fiscal years was modified so as to provide protection for 2 full fiscal years, with authority given to the Chief Medical Director to reduce funding or staffing or both after the first such year based on a real decline in the center's potential workload.

—The S. 1501 provision requiring the conversion, on the date of enactment, from time-limited appointments to career or career-conditional appointments of any employees who had been serving on a time-limited basis for 2 or more years has been modified so as to provide for a delay of 90 days after the enactment date before the conversion would be required.

—The provision in S. 1501 providing an entitlement for readjustment counseling for active-duty personnel who served either during the Vietnam era or since then in combat conditions has been modified so as to make such individuals eligible for—rather than being entitled to—such counseling.

—Authority was added for the Chief Medical Director to establish criteria other than those specified in the bill to be considered before any individual vet center is moved or closed so long as the factor chosen relates to the effective provision of readjustment counseling services.

COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (CBO), estimates that the costs resulting from the enactment of the Committee bill during the first 5 years following enactment would be $35 million in budget authority and outlays in fiscal year 1988; $37 million in budget authority and outlays in fiscal year 1989; $39 million in budget authority and outlays in fiscal year 1990; $40 million in budget authority and outlays in fiscal year 1991; and $42 million in budget authority and outlays in fiscal year 1992. A detailed breakdown of the costs, as estimated by CBO, over the 5-year period follows:

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 28, 1987

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

September 28, 1987

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
U.S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the attached cost estimate for S. 1464, the Veterans' Administration Beneficiary Travel, Quality Assurance, and Readjustment Counseling Amendments of 1987, as ordered reported by the Senate Committee on Veterans' Affairs, July 31, 1987.

Should you so desire, we would be pleased to provide further details on the attached cost estimate. The staff contact is Nina Shepherd (226-2820).

With best wishes,

Sincerely,

Edward M. Gramlich
Acting Director

cc: Honorable Frank H. Murkowski
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 28, 1987

1. BILL NUMBER: S.1464

2. BILL TITLE:

   Veterans Administration Beneficiary Travel, Quality Assurance, and Readjustment Counseling Amendments of 1987.

3. BILL STATUS:

   As ordered reported by the Senate Committee on Veterans' Affairs, July 31, 1987.

4. BILL PURPOSE:

   To provide eligibility to certain individuals for beneficiary travel benefits when traveling to Veterans Administration (VA) medical facilities, and for other purposes.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(By fiscal years, in millions of dollars)

	1988	1989	1990	1991	1992
Estimated Authorization Level	35	37	39	40	42
Estimated Outlays	35	37	39	40	42

The cost of this bill would fall in budget function 700.

Basis of Estimate

Title I. This title would require the Veterans Administration (VA) to reimburse four categories of veterans for the cost of their travel to and from VA facilities for medical care. The four categories of veterans who would be eligible for benefits are: veterans receiving benefits for a service-connected disability; veterans receiving VA pension benefits; veterans whose income is below the income standard for VA pension; and veterans seeking compensation or pension examinations. Veterans requiring special modes of transportation (ambulance, wheelchair van, etc.) would only be eligible for reimbursement if they fell into one of the above categories. The reimbursements would be reduced by a deductible of $3.75 for each one-way trip. Veterans requiring frequent visits to VA medical facilities would not be required to pay total deductibles of more than $22.50 in any calendar month.

The Administrator would retain the authority to eliminate beneficiary travel benefits altogether, but if any benefits were paid, the payments described above would be required.

(By fiscal years, in millions of dollars)	1988	1989	1990	1991	1992
Estimated Authorization Level	33	35	37	38	40
Estimated Outlays	33	35	37	38	40

Prior to April 1987, the categories of veterans listed above were eligible for beneficiary travel reimbursements without a copayment. In April new regulations took effect which limited travel benefits to veterans seeking compensation or pension eligibility examinations, those requiring special modes of transportation, and any others within the eligibility categories who live more than 100 miles from the nearest VA facility. While experience under the new regulations is quite limited, it is estimated that the cost of the program was reduced by between $74 and $95 million a year during the projection period. On the other hand, it is estimated that S.1464 would reduce costs from the pre-April level of operations by only $41 to $55 million over the period, resulting in the net increase over current law cost that is shown above.

The estimate was based on data from three studies: Administration of and Veterans' Participation in the VA Beneficiary Travel Program, U.S. General Accounting Office (GAO/HRD-85-28),February 7, 1985; The Veterans Administration Beneficiary Travel Program, prepared for the U.S. Veterans Administration by Maximus, Inc., March 13, 1985; Study of Health-Care Services to Veterans Living in Geographically Remote Areas, Department of Medicine and Surgery, U.S. Veterans Administration, December, 1985.

Title II. This title would require the VA to establish three new offices to conduct a medical quality assurance program.

(By fiscal years, in millions of dollars)	1988	1989	1990	1991	1992
Estimated Authorization Level	2	2	2	2	2
Estimated Outlays	2	2	2	2	2

This provision would establish the position of Medical Inspector General and would require that the position be supported with a staff of not less than five Assistant Medical Inspectors General and not less than five full-time support positions. Also established would be an Assistant Chief Medical Director for Quality Assurance. Finally, the bill would establish an Assistant Inspector General for Health-Care Quality Assurance Review. A staff of not less than two doctors of medicine, not less than one dentist, not less than one registered nurse, plus at least seven additional full-time positions would be required to support this position.

The estimate assumes that between 26 and 33 additional full-time equivalent staff positions would be required by Title II. The salary levels for these positions are estimated to range from ES-5 to GS-5. It was assumed that the employment ceiling for the VA would be increased to accommodate these positions and that sufficient appropriations would be forthcoming to fully fund their cost.

Title III. This title sets certain restrictions on the relocation of readjustment counseling centers from their current locations to locations within VA medical centers.

It is not expected that the cost of operating readjustment counseling centers would be significantly affected by their relocation to space within VA medical centers. The effect of this title, therefore, is not expected to be significant.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS:

The Congressional Budget Office has determined that the budgets of state and local governments would not be directly affected by enactment of this bill.

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE: None.

9. ESTIMATE PREPARED BY: K.W. Shepherd (226-2820).

10. ESTIMATE APPROVED BY:

James Blum

James L. Blum
Assistant Director
for Budget Analysis

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The results of that evaluation are described below.

The Committee bill would restore certain Veteran's Administration beneficiary travel benefits, upgrade the VA's health-care quality-assurance efforts, expand eligibility for VA readjustment counseling, and place certain limitations and reporting requirements on moving or closing vet centers (through which readjustment counseling is furnished). The Committee finds that the Committee bill would not entail any significant impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

SECTION-BY-SECTION ANALYSIS OF S. 1464 AS REPORTED

Section 1

Subsection (a) of section 1 would provide that this Act may be cited as the "Veterans' Administration Beneficiary Travel, Quality Assurance, and Readjustment Counseling Amendments of 1987".

Subsection (b) of section 1 would provide that, except as otherwise expressly provided, whenever in this Act an amendment or a repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code. This style will likewise be followed in this Analysis.

TITLE I—BENEFICIARY TRAVEL PROGRAM

Section 101

Clause (1) of section 101 would amend present section 111, relating to the authority to pay certain VA beneficiaries for the costs of their travel to and from VA facilities—generally known as "beneficiary travel" payments—to redesignate subsections (b), (c), (d), and (e) as subsections (c), (d), (e), and (f), respectively.

Clause (2) of section 101 would further amend present section 111 to insert a new subsection (b), as follows:

Paragraph (1) of new subsection (b): Would require that—except as provided in new subsection (g) (as proposed to be added by clause (4) of this section of the Committee bill) of section 111 and notwithstanding any other provision of law—if in any fiscal year the Administrator of Veterans' Affairs exercises the authority in section 111 to make any beneficiary travel payments, the Administrator must in that year make the payments provided for in section 111, subject to deductions under paragraph (2) of this new subsection, to or for the following persons traveling for VA health care or examination:

(1) A person receiving benefits under title 38 for or in connection with a service-connected disability.

(2) A veteran receiving pension under section 521 of title 38.

(3) A veteran whose annual income does not exceed the maximum annual rate of pension that would be payable to the veteran if he or she were eligible for pension under section 521.

(4) A veteran who is determined by the Administrator, under regulations prescribed by the Administrator, to be unable to defray the expenses of the travel for which payment is sought.

(5) A veteran whose travel to a VA facility was for a scheduled examination to determine eligibility for compensation or pension.

In current section 111, the Administrator is authorized—and not required—to pay actual necessary expenses of travel, or an allowance in lieu thereof, for travel in connection with examination, treatment, or care, vocational rehabilitation, or certain counseling. Subject to certain limitations discussed below, the persons described in foregoing items (1) through (5) are provided beneficiary travel payments under current law and VA practice. Although the authority to provide payment to all compensation and pension examinees without regard to their eligibility under one of the other four eligibility criteria is not explicit, the Congressional intent in using the phrase "receiving benefits for or in connection with a service connected disability" to denote those eligible for beneficiary travel without regard to financial resources was that the phrase be construed so as to include, among others, those "being examined in connection with a compensation claim". (S. Rept. No. 94-1206, page 77 (1976), accompanying S. 2908, provisions of which relating to beneficiary travel were enacted in section 101(2) of Public Law 94-581.) Under long-standing VA regulations and practice, a claim for pension may be considered a claim for compensation (section 3151 of title 38 of the Code of Federal Regulations) and the examination give veteran claimants for disability benefits is referred to as a "compensation and pension" examination.

Thus, the Committee bill would establish a requirement to pay beneficiary travel in certain circumstances and would clarify the authority to provide beneficiary travel payments to all veterans traveling for compensation and pension examinations.

Under current regulations (section 17.100 of title 38 of the Code of Federal Regulations as amended effective April 13, 1987 (pages 7575-77 of the *Federal Register* for March 12, 1987)), except for travel by ambulance in medical emergencies, other travel by a specific mode of transportation, certain interfacility transfers, or travel for a compensation and pension examination, no payments are made for travel within a 100-mile radius of the VA facility involved and, in the cases of travel to or from outside that radius, a deduction of $11 per one/way trip ($22 for a round trip) is made from the amount otherwise payable.

Subparagraph (A) of paragraph (2) of new subsection (b): Would generally require the VA, in making payments under paragraph (1) of this new subsection, to deduct from the amount otherwise payable $3.75 for each trip to or from a VA facility ($7.50 for a round trip). This deductible would not be charged for travel for a compensation and pension examination or, pursuant to subparagraph (C) of this paragraph, for travel required to be by special mode. Also, the total amount deducted in any one month in the cases of certain pre-approved frequent users of VA care would be limited under subparagraph (B) of this paragraph of new subsection (b) and the amount of the deductible could be periodically adjusted under subparagraph (D) of this paragraph.

The Committee notes its understanding with respect to VA payment for the costs of inter-facility transfers that, although VA regulations authorize beneficiary travel only in certain cases, the VA practice has long been to pay for such transfers from one facility to another using the general health-care authorities in section 610 (relating generally to eligibility for inpatient care) and section 612 (relating to outpatient services), rather than the section 111 limited authority, and using VA medical care account funds other than beneficiary-travel funds. The Committee bill would not affect the VA's authority to provide interfacility-transfer travel either under section 111 or sections 610 and 612.

Subparagraph (B) of paragraph (2) of new subsection (b): Would provide for a cap of $22.50 on the total monthly amount which could be deducted pursuant to subparagraph (A) of this paragraph in certain cases, as follows: In the case of a person who the Administrator determines is required to make six or more one-way trips to or from a VA facility for needed care or services under chapter 17 of title 38, relating to VA health care, during the remainder of the month in which the determination is made or any subsequent calendar month during the one-year period following the month in which the determination is made, no more than $22.50 would be deducted with respect to any travel to or from that facility during any such month. The amount of the cap could be adjusted pursuant to subparagraph (D) of this paragraph of this new subsection (b).

Subparagraph (C) of paragraph (2) of new subsection (b): Would provide (1) that no deduction shall be made pursuant to subparagraph (A) of this paragraph in the case of a person whose travel is required to be performed by a special mode where either authorized in advance or performed in connection with a medical emergency of such a nature that the delay incident to obtaining advance authorization would be hazardous to the patient's life or health, and (2) when it is determined to be in the best interest of furnishing care and services, the VA may, prior to determining the patient's beneficiary travel eligibility, pay the provider of special-mode transportation, subject to later charging the patient for the amount of the travel if the patient is subsequently determined to be ineligible for beneficiary travel benefits.

The Committee notes with respect to special-mode travel that the Committee bill is consistent with current VA regulations, under which no deductible is imposed for such travel and with current law and VA regulations limiting eligibility to those covered by the general eligibility criteria (as described in the foregoing discussion of paragraph (1) of new subsection (b)).

With respect to the provision giving the VA express authority to pay ambulance companies and other providers of special-mode transportation before determining the patient's eligibility, the Committee notes that this provision is intended to clarify the agency's authority to do so, which—in cases not covered by the VA's authority, under section 611(b) of title 38, to furnish hospital care and medical services (which include, by virtue of the definitions in section 601(5) and (6), beneficiary travel benefits under section 111) to ineligible persons in emergencies subject to charging for the care thereafter—may be questionable.

Subparagraph (D) of paragraph (2) of new subsection (b): Would require the Administrator, whenever the Administrator increases or decreases the rates of beneficiary travel allowances or reimbursements paid under section 111, to adjust proportionately, effective on the date on which the increase or decrease takes effect, the deductible amount then in effect under subparagraph (A) of this paragraph and the monthly cap on such deductibles under subparagraph (B). Such alterations of allowances or reimbursements are required to occur in connection with the Administrator's conduct of periodic investigations of VA beneficiary travel costs, which the Administrator must, under subsection (f) (as proposed to be redesignated by clause (1) of this section of the Committee bill) of section 111, conduct immediately after any alteration in the rates of Federal employee travel payments under title 5, United States Codes, and not less often than annually.

Clause (3) of section 101 would amend subsection (f) (as proposed to be redesignated by clause (1) of this section of the Committee bill) of present section 111 to make certain conforming changes in light of new subsection (b) (as proposed to be added by clause (2) of this section of the Committee bill). Thus, this clause would repeal clause (A) of subsection (f), specifying the categories of persons to whom beneficiary travel payments may be made; would redesignate clauses (B) and (C) of subsection (f) as clauses (A) and (B), respectively; and would amend paragraph (4) of subsection (f)—which requires the Administrator, before determining rates under section 111 and no more than 60 days after any alteration in Federal employees' travel rates, to submit to the House and Senate Committees on Veterans' Affairs a report containing the rates that the Administrator proposes to establish or continue—to expand the report to cover the justification for adjusting or leaving unchanged the deductible amount under subparagraph (A) of new subsection (b)(2) and the monthly deductible cap under subparagraph (B) of new subsection (b)(2).

Clause (4) of section 101 would further amend present section 111 to add two new subsections, as follows:

Paragraph (1) of new subsection (g): Would require that, with respect to any fiscal year as to which the Administrator exercises the authority under section 111 to make beneficiary travel payments for travel performed during that fiscal year, the Administrator must, by the later of two dates, the 15th day after the date on which this authority is so exercised or October 1 of that fiscal year, provide each VA medical facility with an allocation for beneficiary travel payments. That allocation would be required to be sufficient to enable the facility to make payments, during the portion of the year beginning on the first day as to which the authority is exercised and ending on the last day of the fiscal year, to all persons eligible for such payments under new subsection (b) of this section (proposed to be added by clause (2) of this section of the Committee bill).

Subparagraph (A) of paragraph (2) of new subsection (g): Would require that, in any fiscal year in which allocations are made pursuant to paragraph (1) of this new subsection, the head of each VA medical facility—unless granted a waiver under subparagraph (B) of this paragraph of new subsection (b) and regulations which the Administrator would be required to prescribe thereunder—utilize the funds so allocated to it solely for the purpose of making beneficiary travel payments under section 111.

Division (i) of subparagraph (B) of paragraph (2) of new subsection (g): Would require the VA's Chief Medical Director (CMD), in any case in which the head of a VA medical facility demonstrates to the CMD that, on April 12, 1987—the day before the date on which the VA regulations reducing beneficiary travel benefits took effect—the facility was making beneficiary travel payments under section 111 at levels less than authorized under section 111, to waive the provisions of new subsection (b) of section 111 (as proposed to be added by clause (2) of this section of the Committee bill), requiring the payment of beneficiary travel benefits in certain cases and to authorize payments to be made at any such prior level of payment or at any higher level proposed by the facility head which is less than what new subsection (b) would otherwise require.

Division (ii) of subparagraph (B) of paragraph (2) of new subsection (g): Would, in any case (other than one described in division (i) of this subparagraph of new subsection (g)) in which the head of a VA medical facility proposes to make beneficiary travel payments under section 111 at a level less than would otherwise be required under new subsection (b) (as proposed to be added by clause (2) of this section of the Committee bill) and the CMD determines that making beneficiary travel payments at that lower level, or a higher one less than the level that would otherwise be required, would be in the best interest of furnishing care and services to veterans at the facility concerned, authorize the CMD to waive the provisions of new subsection (b) and to authorize payments to be made at, as appropriate, the proposed level or at a higher one less than the proposed level and the level that would otherwise be required.

Subparagraph (C) of paragraph (2) of new subsection (g): Would require that, where any beneficiary travel funds which are allocated to a VA medical facility pursuant to paragraph (1) of this new subsection (g) are not, pursuant to a waiver granted under subparagraph (B) of this paragraph of new subsection (g), expended for beneficiary travel purposes, the funds so allocated but not expended would be available for the support of other authorized direct patient-care purposes.

Paragraph (1) of new subsection (h): Would require the Administrator, in consultation and coordination with the Secretary of Transportation and appropriate representatives of veterans' service organizations, to take all appropriate steps to facilitate the establishment and maintenance of a program under which such organizations or individuals volunteering their services to the VA would take responsibility for transporting veterans to VA facilities without reimbursement from the VA—primarily veterans residing in areas which are geographically accessible to such facilities, who seek VA healthcare services or benefits under title 38.

Paragraph (2) of new subsection (h): Would require the Administrator, not later than 6 months after the date of the enactment of this new subsection (h), to submit to the Committees on Veterans'

Affairs of the Senate and the House of Representatives a report on the implementation of this new subsection.

TITLE II—QUALITY ASSURANCE PROGRAM

Section 201

Subsection (a) of section 201 would amend present chapter 73 of title 38, relating to the VA's Department of Medicine and Surgery, to add a new section 4103A, entitled "Office of Medical Inspector General", as follows:

Subsection (a) of new section 4103A: Would establish a new Office of Medical Inspector General (OMIG) in the Office of the Chief Medical Director.

Subsection (b) of new section 4103A: Would specify, in five numbered paragraphs, the minimum staffing requirements of the OMIG, as follows:

Paragraph (1) of subsection (b) of new section 4103A: Would require that there be a Medical Inspector General (MIG) as the head of the OMIG and that the MIG be a qualified doctor of medicine, appointed by the Administrator on the recommendation of the Chief Medical Director (CMD), and directly responsible to the CMD for the functions assigned by the CMD consistent with the provisions of this new section.

Paragraph (2) of subsection (b) of new section 4103A: Would specify that there be not less than five Assistant Medical Inspectors General (AMIGs) in the OMIG who shall be either qualified doctors of medicine or of dental surgery or dental medicine, or registered nurses, all of whom shall be full-time VA employees.

Paragraph (3) of subsection (b) of new section 4103A: Would require that there be not less than two registered nurses in the OMIG who shall be full-time VA employees, either or both of whom may be an AMIG.

Paragraph (4) of subsection (b) of new section 4103A: Would require that there be not less than one qualified doctor of dental surgery or dental medicine in the OMIG who shall be a full-time VA employee and who may be an AMIG.

Paragraph (5) of subsection (b) of new section 4103A: Would require that there be not less than five support personnel in the OMIG who shall be full-time VA employees.

Subsection (c) of new section 4103A: Would provide that the MIG be appointed for a 4-year term with reappointment possible for additional such terms, and be subject to removal by the Administrator only for reasonable cause upon the CMD's recommendation.

Paragraph (1) of subsection (d) of new section 4103A: Would require the MIG to monitor, review, and investigate any adverse incident experienced by a patient while under care in a VA facility, including any incident that would not normally be expected to occur as part of the anticipated course of the patient's disease or illness or that would require medical intervention.

Paragraph (2) of subsection (d) of new section 4103A: Would require the MIG to carry out reviews and investigations necessary to identify problems in the provision of health care to veterans and, when problems are detected as a result of such activities, to propose to the CMD appropriate corrective measures.

Paragraph (3) of subsection (d) of new section 4103A: Would require the MIG to carry out other studies, reviews, and investigations relating to the quality of VA health care as either the Administrator or CMD might assign.

Paragraph (4) of subsection (d) of new section 4103A: Would require that, subject to the Administrator's and the CMD's authority under paragraph (3) of this subsection to require the MIG to carry out certain activities, the MIG have sole discretion in determining whether to investigate any incident involving a VA patient or to carry out a study or review of any possible problem in the provision of VA health care.

Subsection (e) of new section 4103A: Would require that, in carrying out any investigation, study, or review of VA health-care matters, the MIG assign at least one health-care professional from the OMIG.

Subsection (f) of new section 4103A: Would require the MIG to submit, not later than February 1 of each year, to the Administrator, the CMD, and the Veterans' Affairs Committees of the Senate and the House of Representatives, an annual report on the activities of the OMIG during the preceding fiscal year. The annual report would be required to include (1) a description of problems, abuses, and deficiencies in VA health-care programs and operations disclosed by MIG activities during the preceding fiscal year; (2) a description of any recommendations made by the MIG during the preceding fiscal year in connection with deficiencies found by the MIG in VA health-care programs and operations, together with a description of the action taken in response to such recommendations and of those recommendations as to which action has not been completed by the end of the fiscal year; (3) a specification of which of the MIG's activities were carried out on the MIG's own initiative and which were at the direction of the Administrator or CMD; (4) identification of each significant recommendation from the current or prior annual reports on which recommended action has not been completed; (5) a summary of any matters that the MIG has referred to outside authorities for prosecution as well as information on prosecutions and convictions which have resulted from such referrals; and (6) a summary of any incident in which the MIG sought information or assistance from the Department of Medicine and Surgery (DM&S) during the preceding fiscal year and such information or assistance was, in the MIG's judgment, unreasonably refused or not provided.

Subsection (g) of new section 4103A: Would require that the MIG be a nonvoting, ex officio member of all DM&S policymaking bodies within the VA's Central Office that deal with the quality of VA health care or with VA quality-assurance efforts, but not have any direct responsibility for VA quality-assurance efforts, including patient risk-management and the reporting of patient injuries under quality-assurance procedures.

Paragraph (1) of subsection (h) of new section 4103A: Would require the Administrator to transfer to the OMIG each fiscal year, out of any funds available to the VA other than those available for the operation of the DM&S central office (which is funded out of the medical administration and miscellaneous operating expenses appropriations account), funds sufficient, as determined by the

CMD, to support five full-time medical doctors and five full-time support personnel in the OMIG.

Paragraph (2) of subsection (h) of new section 4103A: Would provide that the positions of five full-time medical doctors and five full-time support personnel in the OMIG be counted against the number of full-time employees authorized by the Office of Management and Budget for the entity or entities for which the funds transferred to the OMIG pursuant to paragraph (1) of this subsection would have been available except for such transfer.

Subsection (b) of section 201 would amend the table of sections at the beginning of chapter 73 to reflect the addition of new section 4103A proposed by subsection (a) of this section of the Committee bill.

Section 202

Would amend present section 4103(a)(4) of title 38, relating to the appoinment of Assistant Chief Medical Directors (ACMDs) within the Office of the CMD, to specify that one of the ACMDs be a qualified physician trained in, or with suitable extensive experience in, healthcare quality assurance and risk management and be responsible to the CMD for carrying out the CMD's quality-assurance responsibilities as assigned by the Administrator under subchapter V of chapter 73 as well as any other related responsibilities assigned by the CMD.

Section 203

Would amend present section 4151 of title 38, relating to DM&S quality-assurance programs, to add a new subsection (f), as follows:

New subsection (f) of section 4151: Would require the CMD to take such action as may be necessary to ensure that all DM&S personnel are periodically given an explanation of their responsibilities for quality-assurance activities and are advised that any failure to follow DM&S quality-assurance procedures, including any failure to report to appropriate superiors any adverse incident involving a VA patient, will result in disciplinary action.

Section 204

Paragraph (1) of subsection (a) of section 204 would amend present chapter 3 of title 38, relating to the general structure and functioning of the VA, to add a new subchapter V, entitled "Other Veterans' Administration Offices", consisting of one section, section 250, entitled "Assistant Inspector General for Health Care Quality Assurance Review", as follows:

Subsection (a) of new section 250: Would establish a new position of Assistant Inspector General for Health Care Quality Assurance Review (AIG) in the VA's Office of Inspector General (OIG).

Subsection (b) of new section 250: Would require the Administrator to make sufficient resources available to the OIG to support the AIG as well as associated personnel required by subsection (d) of this new section and to enable the AIG to carry out the duties assigned.

Subsection (c) of new section 250: Would require that the AIG be a qualified doctor of medicine appointed by the VA IG.

Subsection (d) of new section 250: Would require that the staff of the AIG include, at a minimum, two qualified doctors of medicine, a qualified doctor of dental surgery or dental medicine, a qualified registered nurse, an attorney who has expertise in health-care law, an individual who has expertise in health-care quality-assurance and risk-management matters, an individual who has expertise in health-care administration matters, and not less than the equivalent of five full-time support and other personnel to enable the AIG to carry out assigned duties.

Subsection (e) of new section 250: Would require the AIG—in addition to performing (with respect to DM&S activities) such duties prescribed for the VA IG by the Inspector General Act of 1978 as are assigned to the AIG by the IG—(1) to monitor the establishment and implementation of quality-assurance and risk-management programs within DM&S, including doing so by reviewing efforts at individual VA facilities; (2) to monitor the activities of the MIG; (3) to recommend that the MIG carry out investigations that the AIG considers appropriate; (4) to coordinate the AIG's activities with those of the MIG; (5) to review any investigation carried out by the MIG of any adverse incident involving a VA patient and to make recommendations to the MIG for any further action the AIG considers appropriate; (6) to monitor and analyze quality-assurance and risk-management information collected by DM&S, review such information in order to identify information that DM&S should be collecting but is not, and monitor DM&S analysis of trends in the provision of VA health care; (7) to make recommendations to the IG regarding proposed corrective actions on health-care matters; and (8) to monitor action on recommendations relating to health-care matters made by the IG to the Administrator.

Subsection (f) of new section 250: Would require the VA IG to submit, not later than February 1 of each year, to the Administrator and the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report containing (1) a discussion of the activities of the AIG in the preceding fiscal year, including the findings and conclusions made by the AIG as a result of such activities, the recommendations made by the IG to the Administrator for corrective action in DM&S based on such activities, and any corrective actions taken in response to those recommendations; and (2) a discussion of the activities of the AIG in the preceding fiscal year to monitor the MIG, including the findings of the IG and AIG on the MIG's activities during the preceding fiscal year, any recommendations made by the IG to the CMD or Administrator on the basis of the AIG's monitoring of the MIG (including any recommendations for disciplinary or remedial actions), and an assessment of the extent to which the IG has been successful during such preceding fiscal year in bringing about remedial and disciplinary actions recommended by the IG.

Subsection (g) of new section 250: Would require that the rate of pay for the position of AIG be the same as the rate established for other Assistant Inspectors General of the VA. At present, Assistant Inspectors General (AIGs) are paid at Senior Executive Service Level ES-4.

Subparagraph (2) of subsection (a) of section 204 would amend the table of sections at the beginning of chapter 3 to reflect the addition of new subchapter V proposed by paragraph (1) of this subsection of the Committee bill.

Subsection (b) of section 204 would amend present section 4151(e)(2), relating to the requirement that the IG allocate sufficient personnel and other resources to monitor the VA's quality-assurance program, to specify that such resources are to be allocated to the AIG.

TITLE III—VIETNAM VETERANS' READJUSTMENT COUNSELING PROGRAMS

section 301

Clause (1) of subsection (a) of section 301: Would revise subsection (a) of present section 612A of title 38, relating to Vietnam-era veterans' entitlement to readjustment counseling, to designate the existing text as paragraph (1) of such subsection, amend that text, and add new paragraphs (2) and (3) as follows:

Paragraph (1) of revised subsection (a): Would provide entitlement to readjustment counseling services (includes general mental and psychological assessments) to, in addition to veterans of the Vietnam era (as in present subsection (a)), veterans who served on active duty after May 7, 1975, the end of the Vietnam era under current law, in an area during a time during which hostilities, as defined in accordance with new paragraph (3) of this subsection, occurred in such an area.

Paragraph (2) of revised subsection (a): Would provide eligibility, but not entitlement, for readjustment counseling services (including general mental and psychological assessments) to veterans who served on active duty active during World War II or the Korean conflict and to persons who remain on active duty who served either during the Vietnam era or since the end of the Vietnam era in an area during a time during which hostilities, as defined in accordance with new paragraph (3) of this subsection, occurred in such an area. In furnishing services to World War II and Korean conflict veterans, the Administrator would be required to place a particular emphasis on those who engaged in combat with the enemy.

Paragraph (3) of revised subsection (a): Would define the term "hostilities"—as that term is used in paragraph (1) of this revised subsection in connection with determining eligibility for readjustment counseling services for those who served in the Armed Forces after the Vietnam era—as a situation in which members of the Armed Forces were, as determined by the Administrator in consultation with the Secretary of Defense, subjected to danger from armed conflict comparable to the danger which members of the Armed Forces have been subjected during combat with enemy forces.

Clause (2) of subsection (a) of section 301: Would revise present section 612A(d) of title 38, relating to personnel matters in connection with the VA's readjustment counseling program, to designate the existing text as paragraph (1) of such subsection and to add a new paragraph (2) as follows:

Subparagraph (A) of paragraph (2) of revised subsection (d): Would require the conversion of career or career-conditional employment, with competitive status, of any employee of the VA's readjustment counseling program who has satisfactorily completed 2 years of substantially continuous employment in the program under a time-limited appointment and who is employed under such an appointment on or after the ninetieth day after the date of the enactment of this provision. Such a conversion would be required to be completed within 30 days after the date of which the 2-year period of employment expires or 90 days after the date of the enactment of this paragraph, whichever is the later.

Subparagraph (B) of paragraph (2) of revised subsection (d): Would require the Administrator to provide to an individual entitled to conversion under subsection (A) of this paragraph notice of that right—along with a timetable for accomplishing the conversion—not later than 15 days after such entitlement is attained.

Subclause (A) of clause (3) of subsection (a) of section 301: Would revise paragraph (1) of present section 612A(g) of title 38—relating to the requirement that the Administrator take appropriate steps during fiscal years 1988 and 1989 to provide for an orderly, gradual transition by October 1, 1989, of the readjustment counseling program from a program providing such services through centers (referred to as "Vet Centers") located in facilities situated apart from other VA health-care facilities to a program providing such services primarily through general VA health-care facilities and to provide for the continuing availability thereafter of such counseling and related mental health services—so as to repeal this transition requirement and provide for a process involving case-by-case determination, as follows:

Subparagraph (A) of revised paragraph (1): Would prohibit the closure of relocation of any Vet Center in existence on July 1, 1987, unless the VA's Chief Medical Director (CMD) determines, in accordance with regulations issued by the CMD and specific criteria set forth in subsection (B) of this revised paragraph, that such a closure or relocation will not result in any diminution in the continued availability and effective furnishing of readjustment counseling services to those entitled to and in need of such services in the geographic area served by the Vet Center, and the CMD so certifies in a notification to the Committees on Veterans' Affairs of the Senate and the House of Representatives (hereinafter referred to as the "two Veterans' Affairs Committees") at least 60 days prior to any such closure or relocation. Such a notification would also be required to include (1) the CMD's certification of compliance with the requirements of subsection (C) of this revised paragraph, which generally requires that not less than the average budget and personnel ceiling provided to the Vet Center in each of the 3 prior fiscal years will remain available for furnishing readjustment counseling services for 2 full fiscal years following the relocation, and (2) a description of the results of the consideration given to the factors specified in subsection (B) of this revised paragraph.

Subparagraph (B) of revised paragraph (1): Would require the CMD, in making a determination under subsection (A) of this paragraph relating to the impact of the closure or relocation of a Vet Center, to give full consideration to (1) the distribution of Vietnam-era veterans in the geographic area served by the Vet Center and the relationship between such distribution of Vietnam-era veterans and the locations of the Vet Center and the general VA facility at which readjustment counseling would be furnished in a particular geographic area upon the closure or relocation of the Vet Center (hereinafter referred to as the "general VA facility"); (2) the distance between the Vet Center and the general VA facility; (3) the acceptability of the proposed closure or relocation to appropriate staff of both the Vet Center and the general VA facility, to representatives of veterans' service organizations located in the area served by the Vet Center, and to individual veterans who are being furnished readjustment counseling and other services at the Vet Center; (4) the availability of State, local, or private outreach facilities, or other entities in the area served by the Vet Center, which provide assistance to Vietnam-era veterans; (5) the availability of both transportation to and parking at both the Vet Center and th general VA facility; (6) the availability and cost of space in which to furnish readjustment counseling at the general VA facility, and the suitability of such space, including the opportunity to establish a direct entrance into the area where such services would be furnished and the suitability of the environment where counseling services would be furnished; (7) a comparison of recurring non-personnel costs associated with furnishing readjustment counseling services in the Vet Center and in the general VA facility; (8) the impact of a closure or relocation of the Vet Center's program under which veterans who are eligible for readjustment counseling services but are unable to receive such services in the Vet Center are furnished services by private facilities under a fee-basis contract with the VA; (9) the trends in workload over the prior 2 fiscal years at the Vet Center; and (10) other factors, specified in regulations issued by the CMD, which are determined to be relevant in making the determination as to whether a closure or relocation of a Vet Center will result in any diminution in the continued availability of readjustment counseling services.

Subparagraph (C) of revised paragraph: Would require that, except under certain specified conditions, when a Vet Center is relocated to a general VA facility, the relocated center is to be provided for 2 full fiscal years not less than the average annual budget and personnel ceiling provided to the Vet Center in each of the 3 prior fiscal years. The only exception to this requirement would be where the CMD determines at the end of the first full fiscal year following the move that the demand for services at the relocated center—compared with demand at the prior location—no longer justifies the budget and personnel levels required for the first year and the CMD determines that returning the center to a location away from the general VA facility would be highly unlikely to result in demand sufficient to justify those budget and personnel levels. In such a situation, the CMD, after notifying the two Veteran's Affairs Committees of the CMD's determination and the bases therefore, would be authorized to reduce either the budget or personnel ceiling or both to a level appropriate to meet the then current demand.

Subparagraph (D) of revised paragraph (1): Would provide that not more than 5 percent of the Vet Centers in existence on July 1, 1987, may be closed or relocated before the beginning of fiscal year

1989 and that, beginning in fiscal year 1989 and thereafter, any proposal to close or relocate during any fiscal year more than 10 percent of the centers that were in existence on July 1, 1987 (*i.e.*, to close or relocate more than 18), shall be deemed to be an administrative reorganization for the purposes of section 210(b)(2) of title 38, thereby requiring notification to the two Veterans' Affairs Committee of any such plans at the time the President's budget for that fiscal year is submitted (except in the case of any proposed closures or relocations for fiscal year 1989, when such notification may be delayed until the report required by paragraph (2) of this subsection of section 612A on the VA's readjustment counseling program is submitted or until April 1, 1988, whichever is the earlier). In lieu of the detailed plan and justification required by such section 210(b)(2), the Administrator would instead be required to submit a notification as required under subparagraph (A) of this revised paragraph, including information on each Vet Center proposed to be closed or relocated together with a justification for the overall proposed reorganization in light of the contents of the report that the Administrator is required—by paragraph (2) of this subsection of section 612A—to submit by April 1, 1988, setting forth the Administrator's evaluation of the effectiveness of the Readjustment Counseling Program in meeting the readjustment needs of Vietnam-era veterans, especially in light of the study mandated by section 102 Public Law 98-160, relating to post-traumatic stress disorder and other post-war psychological problems among such veterans (hereinafter referred to as the "PTSD study").

Subparagraph (E) of revised paragraph (1): Would define two terms for the purposes of this revised paragraph (1) as follows:

(1) The term "general Veterans' Administration facility" would mean a VA facility, other than a Vet Center, at which readjustment counseling services would be furnished in a geographic area once a Vet Center is closed or relocated.

(2) The term "relocated Vet Center" would mean a Vet Center that has been moved to a general VA facility.

Subclause (B) of clause (3) of subsection (a) of section 301 would amend paragraph (2) of present section 612A(g), relating to report by the Administrator on the effectiveness of the Readjustment Counseling Program and on the need for the program to meet the readjustment needs of Vietnam-era veterans, to (1) postpone by 1 year, from April 1, 1987, the April 1, 1988, the date by which the report is due to be submitted to the two Veterans' Affairs Committees, (2) to delete a reference to the use in the preparation of the report of partial information from the PSTD study if that study is not completed by the due date of the report, (3) substitute a reference to "Vet Centers" (a term that would be defined in subsection (2) of section 612(A) as proposed to be added by clause (6) this subsection of the Committee bill) for the phase "a program providing such services through facilities situated apart from Veterans' Administration health-care facilities", and (4) delete a reference to "paragraph (1)" of section 612A(g) in light of the changes made to that paragraph by subclause (A) of this claude of the Committee bill.

Subclause (C) of clause (3) of subsection (a) section 301 would further amend present section 612A(g) by deleting paragraph (3) and

(4), both of which relate to reports on the mandatory transition of the Readjustment Counseling Program, in light of the elimination of that required transition by subparagraph (A) of this paragraph of the Committee bill.

Clause (4) of subsection (a) of section 301 would redesignate subsection (h) of present section 612A, relating to a pilot program of Vietnam Veteran Resource Centers, as subsection (i).

Clause (5) subsection (a) of section 301 would further amend present section 612A to insert a subsection (h), as follows:

Paragraph (1) of new subsection (h): Would expressly authorize the Administrator to provide to eligible veterans at Vet Centers, in addition to furnishing readjustment counseling services, other services that the Administrator is otherwise authorized to furnish such veterans, including other health-care and health-care-related services and counseling with respect to, and assistance in applying for, all VA benefits and services for which such veterans may be eligible.

Paragraph (2) of new subsection (h): Would authorize the Administrator to assign personnel and other resources to provide at Vet Centers the services authorized by paragraph (1) of this new subsection.

Clause (6) of subsection (a) of section 301 would further amend present section 612A to add a new subsection (j), as follows:

Paragraph (1) of new subsection (j): Would define the term "Vet Centers" to mean facilities which are operated by the VA for the provision of services under section 612A and which are situated apart from general VA health-care facilities.

Paragraph (2) of new subsection (j): Would define the term "Veterans' Administration general health-care facilities" to mean health care-facilities operated by the VA for the furnishing of health-nursing home, domiciliary, and medical care, not limited to services provided through the programs established under section 612A.

Subsection (b) of section 301 would require the Administrator, not later than 150 days after the date of the enactment of this Act, to submit to the two Veterans' Affairs Committees a report on the implementation of the mandate to convert employees pursuant to the amendments made by subsection (a)(2)(B) of this section of the Committee bill and to include in that report information on the number of employees employed on a time-limited appointment on the ninetieth day after such date of enactment, the number, assignment, and duty station of those converted to career or career-conditional appointment by the date 120 days after the date of enactment, and the plans and timetable for accomplishing the conversion of other such employees.

Section 302

Would amend section 102(b) of the Veterans' Health Care Amendments of 1983 (Public Law 98-160), relating to a report that the Administrator is required to submit by October 1, 1986, to the two Veterans' Affairs Committees on the interim results of the PTSD study, to postpone the due date for the report by 1 year until October 1, 1987.

Section 303

Would provide that the functions and authorities assigned to the CMD by any provision of this title of the Committee bill or by any amendment made by this title may not be delegated by the CMD nor exercised by any other official.

Tabulation of Votes Cast in Committee

In compliance with paragraph 7 of the rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or in proxy by members of the Committee on Veterans' Affairs at its July 31, 1987, meeting in connection with S. 1464.

The Committee unanimously agreed to report S. 1464, with an amendment in the nature of a substitute, favorably to the Senate by a vote of 11-0, as follows:

YEAS—11	NAYS—0
Alan Cranston	
Spark M. Matsunaga	
Dennis DeConcini	
George J. Mitchell	
John D. Rockefeller IV	
Bob Graham	
Frank M. Murkowski	
Alan K. Simpson	
Strom Thurmond	
Robert T. Stafford	
Arlen Specter	

During the Committee's consideration of S. 1464, an amendment by Senator Murkowski to strike the provisions of title III, relating to the readjustment counseling program for Vietnam-era veterans, and substitute therefor provisions which would have provided for a one-year postponement, from October 1, 1987, to October 1, 1988, of the date by which the program is required to begin a 2-year transition from a program providing services primarily through Vet Centers to one providing services primarily through the VA's general health-care facilities, was defeated by a vote of 5-6, as follows:

YEAS—5	NAYS—6
Frank M. Murkowski	Alan Cronston
Alan K. Simpson	Spark M. Matsunaga
Strom Thurmond	Dennis DeConcini
Robert T. Stafford	George J. Mitchell
Arlen Specter	John D. Rockefeller IV
	Bob Graham

Agency Reports

On August 7, 1987, the Department of Defense submitted to the Committee of Veterans' Affairs a letter setting forth the Department's views of S. 1501 (from which title III of S. 1464 as reported was derived) which is reprinted below.

On September 28, 1987, the Department of Transportation submitted to the Committee a letter setting forth the Department's views on S. 1464 as introduced (from which title I of S. 1464 as reported was derived) which is reprinted below.

By letters dated July 7, 1987, the Committee requested the Veterans' Administration's view on S. 1443, S. 1444, and S. 1464. By the date on which this report was filed, the VA had not submitted any agency reports on those measures.

THE SECRETARY OF DEFENSE
WASHINGTON, THE DISTRICT OF COLUMBIA

7 AUG 1987

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This letter presents the views of the Department of Defense with respect to Section 3 of S.1501, 100th Congress, a bill to amend Title 38, United States Code, to eliminate the requirement that the Administrator of Veterans Affairs carry out a transition under which community based Vet Centers would be moved to Veterans Administration medical facilities, and for other purposes.

Section 3 of S.1501 would establish authority for the Veterans Administration to furnish psychological counseling to active duty military personnel who had served on active duty during the Vietnam era or during a period of hostilities. By permitting the Veterans Administration to furnish counseling to assist such persons in "readjusting to active duty" following such service, S.1501 circumvents the primary goal of the Military Health Care System which is to maintain the medical (including psychological) readiness of the active duty force.

The Department of Defense is strongly opposed to the readjustment counseling program provisions of Section 3 as they pertain to active duty personnel. The Department of Defense operates a comprehensive health care system which provides quality psychological counseling to all active duty personnel in need of such care. Further, it is imperative that the Department remain fully cognizant of the psychological status of its active duty personnel. The Military Health Services System (MHSS) maintains a medical record on every active duty person that is annotated each time this member seeks care. By retaining responsibility for providing medical care to all active duty personnel, the MHSS ensures that a complete record of each individual's medical and psychological history is maintained. These records form the basis for medical opinions concerning flight status, fitness for duty, security clearances, and a host of other equally important medical readiness determinations. Should these records be incomplete because medical treatment was provided by another agency, one of these determinations could be fatally flawed.

Accordingly, the Department is opposed to this provision of S.1501 and any provision that would permit the Veterans Administration to provide medical or psychological care to an active duty member except under a formal VA/DoD Sharing Agreement entered into under P.L. 97-174. The Administration continues to support taking advantage of mutually beneficial opportunities for sharing health care resources in accordance with the Sharing Act.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the presentation of this report for the consideration of the Committee.

Sincerely,

U.S. Department of Transportation

General Counsel

400 Seventh St., S.W.
Washington, D.C. 20590

SEP 28 [illegible]

The Honorable Alan Cranston
Chairman, Committee on
  Veterans Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Secretary Dole asked that I respond to your July 8, 1987, request for the Department of Transportation's views concerning S. 1464, the

> "Veterans Beneficiary Travel Reimbursement Restoration Act of 1987".

The bill would amend Section 111 of title 38, United States Code, which addresses the matter of payment of travel expenses of Veterans Administration (VA) beneficiaries in great detail. This Department defers to the Veterans Administration on the merits of the proposed amendments.

One element of the proposed amendments directs the VA Administrator, "in consultation and coordination with the Secretary of Transportation" and others, to facilitate establishment of a program by which beneficiary travel services could be volunteered at no cost to the government. While we believe the VA is fully capable of addressing this matter without this Department's involvement, we do not object to playing an appropriate role. We would note that other provisions of Section 111 establish a Department of Transportation consultation role, but not a "consultation and coordination" role. We do not believe coordination of any such voluntary service program with the Department would be necessary.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the submission of this report for the consideration of the Committee.

Sincerely,

B. Wayne Vance
General Counsel

Changes in Existing Law Made by S. 1464 as Reported

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

* * * * * * *

PART I—GENERAL PROVISIONS

* * * * * * *

CHAPTER 1—GENERAL

* * * * * * *

§ 111. Travel expenses

(a) * * *

* * * * * * *

(b)(1) Except as provided in subsection (g) of this section and notwithstanding subsection (f)(2)(A) of this section or any other provision of law, if, with respect to any fiscal year, the Administrator exercises the authority under this section to make any payments, the Administrator, in such fiscal year, shall make the payments provided for in this section, subject to any applicable deduction under paragraph (2) of this subsection, to or for the following persons for travel for examination, treatment, or care:

(A) A person receiving benefits under this title for or in connection with a service-connected disability.

(B) A veteran receiving pension under section 521 of this title.

(C)(i) A veteran whose annual income, determined in accordance with section 503 of this title, does not exceed the maximum annual rate of pension which would be payable to such veteran if such veteran were eligible for pension under section 521 of this title, or (ii) a veteran who is determined, under regulations prescribed by the Administrator, to be unable to defray the expenses of the travel for which payment under this section is claimed.

(D) A veteran whose travel to a Veterans' Administration facility was incident to a scheduled compensation and pension examination.

(2)(A) Except as provided in subparagraph (B), (C), or (D) of this paragraph, the Administrator, in making a payment under this section to or for a person described in subparagraphs (A), (B), or (C) of paragraph (1) of this subsection for travel for examination, treatment, or care, shall deduct from the amount otherwise payable an amount equal to $3.75 for one-way each trip.

(B) In the case of a person who is determined by the Administrator to be a person who is required to make six or more one-way trips

for needed examination, treatment, or care during the remainder of the calendar month in which the determination is made or during any subsequent calendar month during the one-year period following the last day of the month in which the determination is made, the amount deducted by the Administrator pursuant to subparagraph (A) of this paragraph from payments for trips made to or from such facility during any such month shall not, except as provided in subparagraph (D) of this paragraph, exceed $22.50.

(C) No deduction shall be made pursuant to subparagraph (A) of this paragraph in the case of a person whose travel to or from a Veterans' Administration facility was required to be performed by a special mode of travel and such travel (i) was authorized by the Administrator before such travel was commenced, or (ii) was in connection with a medical emergency of such a nature that the delay incident to obtaining authorization under clause (i) of this subparagraph would have been hazardous to the person's life or health. In the case of such travel, if the Administrator determines that providing payment prior to determining the eligibility of such person is in the best interest of furnishing care and services, the Administrator may so provide payment to the provider of the transportation subject to subsequently recovering from such person the amount of the payment if such person is determined to have been ineligible for payment for such travel.

(D) Whenever the Administrator increases or decreases the rates of allowances or reimbursement to be paid under this section, the Administrator shall, effective on the date on which such increase or decrease takes effect, adjust proportionately the dollar amounts specified in subparagraphs (A) and (B) of this paragraph as such amounts may have been increased or decreased pursuant to this subparagraph prior to such date.

[(b)]*(c)* Payment of the following expenses or allowances in connection with vocational rehabilitation, counseling, or upon termination of examination, treatment, or care, may be made before the completion of travel:

(1) the mileage allowance authorized by subsection (a) hereof;

(2) actual local travel expenses;

(3) the expense of hiring an automobile or ambulance, or the fee authorized for the services of a nonemployee attendant.

[(c)]*(d)* When any person entitled to mileage under this section requires an attendant (other than an employee of the Veterans' Administration) in order to perform such travel, the attendant may be allowed expenses of travel upon the same basis as such person.

[(d)]*(e)* The Administrator may provide for the purchase of printed reduced-fare requests for use by veterans and their authorized attendants when traveling at their own expense to or from any Veterans' Administration facility.

[(e)]*(f)*(1) In carrying out the purposes of this section, the Administrator, in consultation with the Administrator of General Services, the Secretary of Transportation, the Comptroller General of the United States, and representatives of organizations of veterans, shall conduct periodic investigations of the actual cost of travel (including lodging and subsistence) to beneficiaries while traveling to or from a Veterans' Administration facility or other place pursuant to the provisions of this section, and the estimated cost of alternative modes of travel, including public transportation and the operation of privately owned vehicles. The Administrator shall conduct such investigations immediately following any alteration in the rates described in paragraph (3)(C) of this subsection, and, in any event, immediately following the enactment of this subsection and not less often than annually thereafter, and based thereon, shall determine rates of allowances or reimbursement to be paid under this section.

(2) In no event shall payment be provided under this section—

(A) unless the person claiming reimbursement has been determined, pursuant to regulations which the Administrator shall prescribe, to be unable to defray the expenses of such travel (except with respect to a person receiving benefits for or in connection with a service-connected disability under this title, a veteran receiving or eligible to receive pension under section 521 of this title, or a person whose annual income, determined in accordance with section 503 of this title, does not exceed the maximum annual rate of pension which would be payable to such person if such person were eligible for pension under section 521 of this title);

(B) to reimburse for the cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless (i) public transportation is not reasonably accessible or would be medically inadvisable, or (ii) the cost of such travel is not greater than the cost of public transportation; and

(C) in excess of the actual expense incurred by such person as certified in writing by such person.

(3) In conducting investigations and determining rates under this section, the Administrator shall review and analyze, among other factors, the following factors:

(A) (i) Depreciation of original vehicle costs;

(ii) gasoline and oil costs;

(iii) maintenance, accessories, parts, and tire costs;

(iv) insurance costs; and

(v) State and Federal taxes.

(B) The availability of and time required for public transportation.

(C) The per diem rates, mileage allowances, and expenses of travel authorized under sections 5702 and 5704 of title 5 for employees of the United States.

(4) Before determining rates *or adjusting amounts* under this section and not later than sixty days after any alteration in the rates described in paragraph (3)(C) of this subsection, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the rates *and amounts* the Administrator proposes to establish or continue with a full justification therefor in terms of each of the limitations and factors set forth in this section.

(g)(1) Whenever the Administrator exercises with respect to any fiscal year the authority to make payments under this section, the Administrator shall, not later than the fifteenth day after the date on which the Administrator so exercises such authority or the first day of such year, whichever is the later, make an allocation to each

Veterans' Administration medical facility sufficient to enable the head of such facility to make such payments during the portion of the year beginning on the first day as to which the authority is exercised and ending on the last day of such year to persons eligible for such payments under subsection (b) of this section.

(2)(A) In any fiscal year in which funds are allocated pursuant to paragraph (1) of this subsection, the head of each such facility, unless granted a waiver under subparagraph (B) of this paragraph and regulations which the Administrator shall prescribe thereunder, shall utilize such funds solely for the purpose of making payments under this section.

(B)(i) In any case in which the head of such a facility demonstrates to the Chief Medical Director that, on April 12, 1987, such facility was making payments under this section at an annual expenditure less than the annual expenditure level would have been if such payments were being made to all eligible persons in the maximum amounts then authorized under this section, the Chief Medical Director shall waive provisions of subsection (b) of this section and authorize payments to be made at any such prior level or at any higher level, proposed by such facility head, that is less than the level that would otherwise be provided for under this section.

(ii) In any other case in which the head of such a facility proposes to make payments under this section at an annual expenditure level less than the level that would otherwise be provided for under this section, if the Chief Medical Director determines that making payments at such lesser level, or any higher level that is less than the level that would otherwise be provided for under such subsection, would be in the best interest of furnishing care and services to eligible veterans at such facility, the Chief Medical Director may waive the provisions of subsection (b) of this section and authorize payments to be made at the level specified in the Chief Medical Director's determination.

(C) Any funds which are allocated to a facility pursuant to paragraph (1) of this section for the purpose of payments under this section but which, pursuant to a waiver granted under subparagraph (B) of this paragraph, are not expended for such purpose shall be available to the head of such facility to be expended for direct patient-care services.

(h)(1) The Administrator, in consultation and coordination with the Secretary of Transportation and appropriate representatives of veterans' service organizations, shall take all appropriate steps to facilitate the establishment and maintenance of a program under which such organizations, or individuals who are volunteering their services to the Veterans' Administration, would take responsibility for the transportation, without reimbursement from the Veterans' Administration, to Veterans' Administration facilities of veterans, primarily those residing in areas which are geographically accessible to such facilities, who seek services or benefits from the Veterans' Administration under chapter 17 or other provisions of this title.

(2) Not later than 6 months after the date of the enactment of this subsection, the Administrator shall submit to the Committees on

Veterans' Affairs of the Senate and the House of Representatives a report on the implementation of this subsection.

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CHAPTER 3—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

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SUBCHAPTER V—OTHER VETERANS' ADMINISTRATION OFFICES

250. Assistant Inspector General for Health Care Quality Assurance Review.

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SUBCHAPTER V—OTHER VETERANS' ADMINISTRATION OFFICES

§ 250. Assistant Inspector General for Health Care Quality Assurance Review

(a) There is established in the Veterans' Administration Office of the Inspector General, in addition to the positions of Assistant Inspector General of the Veterans' Administration provided under section 3(d) of the Inspector General Act of 1978 (5 U.S.C. App. 3), the position of Assistant Inspector General for Health Care Quality Assurance Review.

(b) The Administrator shall make available to the Office of the Inspector General sufficient resources to provide for an Assistant Inspector General for Health Care Quality Assurance Review and the personnel required by subsection (d) of this section and to enable such Assistant Inspector General and personnel to perform the duties of such Assistant Inspector General.

(c) The Assistant Inspector General for Health Care Quality Assurance Review shall be a qualified doctor of medicine appointed by the Inspector General of the Veterans' Administration.

(d) The staff of the Assistant Inspector General for Health Care Quality Assurance Review shall include the following:

(1) Not less than two qualified doctors of medicine.

(2) Not less than one qualified doctor of dental surgery or dental medicine.

(3) Not less than one qualified registered nurse.

(4) Not less than one attorney who has expertise in health-care law.

(5) Not less than one individual who has expertise in health-care quality assurance and risk management.

(6) Not less than one individual who has expertise in health-care administration.

(7) A sufficient number of support and additional personnel, but not less than the equivalent of five full-time personnel, to enable the Assistant Inspector General for Health Care Quality Assurance Review to perform the duties of such Assistant Inspector General.

(e) The Assistant Inspector General for Health Care Quality Assurance Review, in addition to performing (with respect to activities of the Department of Medicine and Surgery) such other functions and duties prescribed for the Inspector General of the Veterans' Administration in the Inspector General Act of 1978 (5 U.S.C. App. 3) as may be directed by the Inspector General, shall—

(1) monitor, including through reviews of Veterans' Administration health-care facilities, the establishment and implementation of the health-care quality assurance and risk management programs of the Department of Medicine and Surgery;

(2) monitor the activities of the Medical Inspector General of the Department of Medicine and Surgery;

(3) recommend that the Medical Inspector General of the Department of Medicine and Surgery conduct such investigations as the Assistant Inspector General for Health Care Quality Assurance Review considers appropriate;

(4) coordinate the activities of the Assistant Inspector General with the activities of the Medical Inspector General of the Department of Medicine and Surgery;

(5) review any investigation conducted by the Medical Inspector General of the Department of Medicine and Surgery of any adverse incident or incidents occurring during the course of furnishing health-care services in a Veterans' Administration facility or facilities and make such recommendations for additional action to such Medical Inspector General as the Assistant Inspector General considers appropriate;

(6) monitor and analyze the collection and analysis of quality assurance and risk management information by the Department of Medicine and Surgery (including information relating to medical malpractice claims), review such quality assurance and risk management information in order to identify data that is not collected and should be collected, and monitor the analysis by the Department of Medicine and Surgery of trends in the provision of health-care services by such Department;

(7) make to the Inspector General such recommendations for corrective action on health-care matters as the Assistant Inspector General considers appropriate; and

(8) monitor the implementation of recommendations for corrective action made to the Administrator by the Inspector General on health-care matters.

(f) The Inspector General of the Veterans' Administration, in addition to preparing and submitting the reports required by the Inspector General Act of 1978 (5 U.S.C. App. 3), shall submit to the Administrator and the Committee on Veterans' Affairs of the Senate and the House of Representatives, not later than February 1 of each year, a report containing—

(1) a discussion of the activities undertaken by the Assistant Inspector General for Health Care Quality Assurance Review during the fiscal year preceding the fiscal year in which the report is submitted, including—

(A) the findings and conclusions resulting from such activities;

(B) the recommendations made (on the basis of such activities) by the Inspector General to the Administrator for

corrective action in the activities of the Department of Medicine and Surgery; and

(C) any corrective actions taken with respect to those recommendations; and

(2) a discussion of the activities undertaken by the Assistant Inspector General for Health Care Quality Assurance Review to monitor the activities of the Medical Inspector General of the Department of Medicine and Surgery during the fiscal year preceding the fiscal year in which the report is submitted, including—

(A) the findings of the Inspector General of the Veterans' Administration and the Assistant Inspector General on the activities of the Medical Inspector General during such preceding fiscal year;

(B) the recommendations, if any, made by the Inspector General of the Veterans' Administration to the Chief Medical Director or the Administrator on the basis of such monitoring activities, including any recommendations for remedial or disciplinary actions as a result of such activities; and

(C) an assessment of the extent to which the Inspector General has been effective during such preceding fiscal year in bringing about such recommended remedial and disciplinary actions.

(g) The rate of pay for the position of Assistant Inspector General for Health Care Quality Assurance Review shall be the same rate of pay established for the positions of the other Assistant Inspectors General of the Veterans' Administration.

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

* * * * * * *

§ 612A. Eligibility for readjustment counseling and related mental health services

(a)*(1)* Upon the request of [any veteran who served on active duty during the Vietnam era, the Administrator shall, within the limits of Veterans' Administration facilities, furnish counseling to such veteran to assist such veteran in readjusting to civilian life.]—

(A) any veteran who served on active duty during the Vietnam era, or

(B) any veteran who served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in paragraph (3) of this subsection) occurred in such area,

the Administrator shall furnish counseling to assist such veteran in readjusting to civilian life. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran has mental or psychological problems associated with readjustment to civilian life.

(2) Upon the request of (A) any veteran who served on active duty during World War II or the Korean conflict, or (B) any person who is serving on active duty and who served on active duty during either of the periods described in clause (A) or (B) of the first sentence of paragraph (1) of this subsection, the Administrator may furnish counseling to such veteran or person in overcoming any psychological problems associated with such veteran's or person's service during such period. In furnishing counseling under clause (A) of the first sentence of this paragraph, the Administrator shall place particular emphasis on the needs of those who engaged in combat with the enemy. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran or person has mental or psychological problems associated with such veteran's or person's active military, naval, or air service.

(3) For the purposes of subparagraph (1)(B) of this subsection, the term "hostilities" means a situation in which members of the Armed Forces were, as determined by the Administrator in consultation with the Secretary of Defense, subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in battle with the enemy during a period of war.

* * * * * * *

(d)*(1)* The Chief Medical Director may provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively, and, in carrying out this section, may utilize the services of paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 1685 of this title) in initial intake and screening activities.

(2)(A) Any individual who has satisfactorily completed 2 years of substantially continuous employment in the program established to carry out this section under a time-limited appointment and who is so employed on the ninetieth day after the date of the enactment of this paragraph shall be converted by the Administrator to career-conditional or career employment. Such conversion shall be accomplished not later than (i) 30 days after the date on which such 2-year period has expired, or (ii) 120 days after the date of the enactment of this paragraph, whichever is the later. An employee converted under this paragraph shall automatically acquire a competitive status.

(B) Not later than 15 days after an individual becomes entitled to conversion under subparagraph (A) of this paragraph, the Adminis-

trator shall notify such individual of such entitlement and the timetable for such employee's conversion.

* * * * * * *

(g)[(1) During the 24-month period ending on September 30, 1989, the Administrator shall take appropriate steps to ensure—

[(A) the orderly, gradual transition, by October 1, 1989, of that part of the program established under this section for the provision of readjustment counseling services by Veterans' Administration personnel from a program providing such services primarily through centers located in facilities situated apart from the health-care facilities operated by the Veterans' Administration for the provision of other health-care services under other provisions of this chapter to a program providing readjustment counseling services primarily through such health-care facilities; and

[(B) the continued availability after such date of readjustment counseling and related mental health services under this section to veterans eligible for the provision of such counseling and services who request such counseling.]

(1)(A) No Vet Center in existence on July 1, 1987, may be closed or relocated to another location unless the Chief Medical Director—

(i) determines, in accordance with subparagraph (B) of this paragraph and pursuant to regulations prescribed by the Chief Medical Director, that such closure or relocation will not result in any diminution in the continuing availability and effective furnishing of readjustment counseling services to persons entitled to and needing such services in the geographic area served by such Vet Center, and so certifies in the notification described in clause (iii) of this subparagraph;

(ii) in the case of such a relocation, certifies in such notification that the requirements of subparagraph (C) of this paragraph will be met; and

(iii) provides to the Committees on Veterans' Affairs of the Senate and the House of Representatives at least 60 days prior to any such closure or relocation a notification thereof, including a description of the results of the consideration given to the factors specified in subparagraph (B) of this paragraph.

(B) In making a determination under clause (i) of subparagraph (A) of this paragraph, the Chief Medical Director shall give full consideration to—

(i) the distribution of Vietnam-era veterans in the geographical area served by the existing Vet Center and the relationships between the location of such Vet Center and the general Veterans' Administration facility and such distribution;

(ii) the distance between the existing Vet Center and the general Veterans' Administration facility;

(iii) the acceptability of the proposed closure or relocation to (I) the staff of both the existing Vet Center and the general Veterans' Administration facility, (II) representatives of veterans' service organizations located in the geographic area served by the existing Vet Center, and (III) individual veterans who are being furnished services at the existing Vet Center;

(iv) the availability of other entities, such as State, local, or private outreach facilities, which provide assistance to Vietnam-era veterans in the area served by the existing Vet Center;

(v) the availability of transportation to, and parking at, the existing Vet Center and the general Veterans' Administration facility;

(vi) the availability, cost, and suitability of the space at the general Veterans' Administration facility, including the opportunity to establish a direct entry into the area where readjustment counseling services would be furnished and the suitability of the environment where such services would be furnished;

(vii) a comparison of the recurring non-personnel costs of providing readjustment counseling to the same estimated number of veterans at the existing Vet Center and the general Veterans' Administration facility;

(viii) the impact of the proposed closure or relocation on the program at the existing Vet Center pursuant to which eligible veterans are furnished readjustment counseling services by private facilities under a contract with the Veterans' Administration; and

(ix) the workload trends over the prior 2 fiscal years at the existing Vet Center; and

(x) such other factors, specified in the regulations prescribed under subparagraph (A)(i) of this paragraph, as the Chief Medical Director determines are relevant to making the determination described in such subparagraph (A)(i).

(C)(i) Except as provided in division (ii) of this subparagraph, in the case of a relocation of a Vet Center to a general Veterans' Administration facility, not less than the average annual budget and personnel ceiling provided to such Vet Center in each of the 3 fiscal years prior to such relocation (calculated on an annualized basis for any year in which a Vet Center was not operational for an entire year) will remain available to furnish readjustment counseling services for 2 full fiscal years following such relocation.

(ii) In the event that the Chief Medical Director determines at the end of the first full fiscal year following such relocation that the demand for services at the relocated Vet Center's current location, when compared with the demand for services at such Vet Center's prior location, does not then justify the budget and personnel ceiling levels described in division (i) of this subparagraph, the Chief Medical Director may, as an exception to such division, reduce such levels to such levels needed to meet such demand and the estimated future demand for such services if (I) the Chief Medical Director determines that relocation of the Vet Center to a location away from the general Veterans' Administration facility is highly unlikely to result in a demand sufficient to justify the levels initially provided, and (II) the Chief Medical Director promptly notifies the Committees on Veterans' Affairs of the Senate and the House of Representatives of such determinations and the bases therefor.

(D)(i)(I) Any proposed closure or relocation during any fiscal year after fiscal year 1988 of more than 10 percent of the Vet Centers in existence on July 1, 1987, shall be deemed to be an administrative reorganization for the purposes of section 210(b)(2) of this title.

(II) Not more than 5 percent of the Vet Centers (including relocated Vet Centers) in existence on July 1, 1987, may be closed or relocated to a general Veterans' Administration facility prior to October 1, 1988.

(ii)(I) Except as provided in subdivision (II) of this division, in the event of a proposed administrative reorganization as described in division (i) of this subparagraph, the Administrator, at the time specified in subparagraph (A) of such section 210(b)(2), shall submit, in lieu of a report containing a detailed plan and justification, a notification as described in subparagraph (A)(iii) of this paragraph including information as to each Vet Center or relocated Vet Center that is proposed to be closed or relocated and a justification of such proposed administrative reorganization in light of the contents of the report required to be submitted by paragraph (2) of this subsection, particularly the contents of such report in response to the requirement in the second sentence of subparagraph (A) of such paragraph.

(II) In the event of a proposed administrative reorganization as described in division (i) of this subparagraph which is proposed to take effect in fiscal year 1989, the Administrator may delay submitting the notification described in subdivision (I) of this division until the date on which the report required by subsection (g)(2) of this section is submitted or to April 1, 1988, whichever is the earlier.

(E) For the purposes of this paragraph—

(i) the term "general Veterans' Administration facility" means a Veterans' Administration facility which is not a Vet Center and at which readjustment counseling would be furnished in a particular geographic area upon the closure or relocation of a Vet Center; and

(ii) the term "relocated Vet Center" means a Vet Center that has been relocated to a general Veterans' Administration facility.

(2)(A) Not later than April 1, [1987,] *1988,* the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the Administrator's evaluation of the effectiveness in helping to meet the readjustment needs of veterans who served on active duty during the Vietnam era of the readjustment counseling and mental health services provided pursuant to this section (and of outreach efforts with respect to such counseling and services). Such report shall give particular attention, in light of the results of the study required by section 102 of the Veterans' Health Care Amendments of 1983 (Public Law 98-160) [(or, if the study is not then completed, whatever information from it is then available)] to the provision of such counseling and services to veterans with post-traumatic stress disorder and to the diagnosis and treatment of such disorder.

(B) The report required by subparagraph (A) of this paragraph shall include—

(i) the opinion of the Administrator with respect to (I) the extent to which the readjustment needs of veterans who served on active duty during the Vietnam era remain unmet, and (II) the extent to which the provision of readjustment counseling services under this section in [a program providing such services through facilities situated apart from Veterans' Administration health-care facilities] *Vet Centers* is needed to meet such needs; and

(ii) in light of the opinion submitted pursuant to clause (i) of this subparagraph, such recommendations for amendments to [paragraph (1) of] this subsection and for other legislative and administrative action as the Administrator considers appropriate.

[(3) Not later than July 1, 1987, the Administrator shall submit to such committees a report containing a description of the plans made and timetable for carrying out paragraph (1) of this subsection. Such report shall be prepared taking into consideration the results of the study referred to in paragraph (2)(A) of this subsection (or, if the study is not then completed, whatever information from it is then available).

[(4) Not later than February 1, 1989, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under as much of the transition as was carried out pursuant to paragraph (1) of this subsection before September 30, 1988, including such recommendations for legislative and administrative action as the Administrator considers appropriate in light of such experience.]

(h)(1) The Administrator may provide to eligible veterans at Vet Centers, in addition to furnishing readjustment counseling services under this section, other services (including counseling with respect to, and assistance in applying for, all benefits and services under laws administered by the Veterans' Administration for which such veterans may be eligible) that the Administrator is authorized to furnish such veterans.

(2) The Administrator may assign such personnel and other resources as are necessary to provide such additional services under this subsection and are otherwise available to the Administrator for such purpose.

[(h)]*(i)*(1) During the period beginning on January 1, 1986, and ending on September 30, 1988, the Administrator shall conduct a pilot program to provide and coordinate the provision of services described in paragraph (2) of this subsection. The pilot program shall be carried out in order to evaluate the effectiveness, feasibility, and desirability of providing veterans eligible for readjustment counseling under this section with additional services through facilities furnishing such counseling.

(2) The services referred to in paragraph (1) of this subsection are—

(A) counseling with respect to, and assistance in applying for, all benefits and services under laws administered by the Veterans' Administration for which veterans participating in the pilot program may be eligible;

(B) employment counseling, training, placement, and related services described in sections 2003 and 2003A of this title or provided under any other law administered by the Secretary of Labor;

(C) initial intake and referral services with respect to disabilities related to alcohol or drug dependence or abuse and follow-up services for veterans who have received treatment for such disabilities; and

(D) assistance in coordinating the provision of benefits and services to veterans participating in the pilot program with respect to such veterans' receipt of—

(i) services provided under the pilot program; and

(ii) other benefits and services provided under laws administered by the Veterans' Administration, the Secretary of Labor, or any other Federal agency or official.

(3)(A) In order to carry out the pilot program, the Administrator shall—

(i) designate as sites for demonstration projects 10 facilities which on December 3, 1985, are providing readjustment counseling under this section; and

(ii) assign such staff and other resources to such facilities as are necessary to enable such facilities to provide the services referred to in subparagraphs (A) and (C) of paragraph (2) of this subsection.

(B) Facilities designated under subparagraph (A) of this paragraph shall be known as Vietnam Veteran Resource Centers (hereinafter in this subsection referred to as "Centers").

(4) The Administrator—

(A) shall be responsible for coordinating the assignment and use of employees, on full- or part-time bases, as appropriate, in each Center; and

(B) shall, in carrying out that responsibility, make maximum feasible use of the Veterans' Administration employees who are providing services at each facility on the date it is designated as a Center under this subsection.

(5) The Secretary of Labor shall provide for the assignment to each Center, on full- or part-time bases, as the Secretary considers appropriate, of disabled veterans' outreach specialists appointed under section 2003A of this title or employees on the staffs of local employment service offices who are assigned to perform services under section 2004 of this title.

(6) Not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the pilot program during its first 15 months of operation. This report shall include—

(A) the Administrator's assessment of—

(i) the effectiveness of the pilot program in providing and coordinating the provision of the services described in paragraph (2) of this subsection and counseling and services furnished under subsections (a) and (b) of this section; and

(ii) the appropriateness of the use of the personnel assigned to the program;

(B) a description of any administrative action that the Administrator plans to take generally to increase the coordination of the provision of such services to veterans eligible for readjustment counseling services under this section;

(C) any recommendations that the Administrator considers appropriate; and

(D) a comparison of such assessment, plans, and recommendations with the evaluation of and the recommendations relating to the readjustment counseling program included in the report required by subsection (g)(2) of this section.

(7) Not later than January 1, 1989, the Administrator shall submit to such Committees a final report on the pilot program. The report shall include—

(A) updates of all information provided in the report submitted pursuant to paragraph (6) of this subsection; and

(B) the Administrator's final assessment of the pilot program based on 33 months of operation.

(j) For the purposes of this section:

(1) The term "Vet Centers" mean facilities (including Centers) which are operated by the Veterans' Administration for the provision of services under this section and which (except in the cases of "relocated Vet Centers" (as that term is defined in subsection (g)(1) of this section)) are situated apart from Veterans' Administration general health-care facilities.

(2) The term "Veterans' Administration general health-care facilities" means health-care facilities which are operated by the Veterans' Administration for the furnishing of health-care services under this chapter, not limited to services provided through the programs established under this section.

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PART V—BOARDS AND DEPARTMENTS

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CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

SUBCHAPTER I—ORGANIZATION; GENERAL

Sec.
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4102. Divisions of Department.
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SUBCHAPTER I—ORGANIZATION; GENERAL

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§ 4103. Office of the Chief Medical Director

(a) The Office of the Chief Medical Director shall consist of the following—

(1) The Chief Medical Director, who shall be the Chief of the Department of Medicine and Surgery and shall be directly responsible to the Administrator for the operations of the Department, and who shall be a qualified doctor of medicine, appointed by the Administrator.

(2) The Deputy Chief Medical Director, who shall be the principal assistant of the Chief Medical Director, and who shall be a qualified doctor of medicine, appointed by the Administrator upon the recommendation of the Chief Medical Director.

(3) The Associate Deputy Chief Medical Director, who shall be an assistant to the Chief Medical Director and the Deputy Chief Medical Director, and who shall be a qualified doctor of medicine, appointed by the Administrator upon the recommendation of the Chief Medical Director.

(4) Not to exceed eight Assistant Chief Medical Directors, who shall be appointed by the Administrator upon the recommendation of the Chief Medical Director. Not more than two Assistant Chief Medical Directors may be persons qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicines. One Assistant Chief Medical Director shall be a qualified doctor of dental surgery or dental medicine who shall be directly responsible to the Chief Medical Director for the operation of the Dental Service. One Assistant Chief Medical Director shall be a qualified physician trained in, or having suitable extensive experience in, geriatrics who shall be responsible to the Chief Medical Director for evaluating all research, educational, and clinical health-care programs carried out in the Department in the field of geriatrics and who shall serve as the principal advisor to the Chief Medical Director with respect to such programs. *One Assistant Chief Medical Director shall be a qualified physician trained in, or having suitable extensive experience in, health-care quality assurance and risk management who shall be responsible to the Chief Medical Director for carrying out the responsibilities assigned to the Chief Medical Director in subchapter V of this chapter and such related responsibilities as are assigned to the Assistant Chief Medical Director by the Chief Medical Director.*

(5) Such Medical Directors as may be appointed by the Administrator, upon the recommendation of the Chief Medical Director, to suit the needs of the Department. A Medical Director shall be either a qualified doctor of medicine or a qualified doctor of dental surgery or dental medicine.

(6) A Director of Nursing Service, who shall be a qualified registered nurse, appointed by the Administrator, and who shall be responsible to the Chief Medical Director for the operation of the Nursing Service.

(7) A Director of Pharmacy Service, a Director of Dietetic Service, a Director of Podiatric Service, and a Director of Optometric Service, appointed by the Administrator, and who shall

be responsible to the Chief Medical Director for the operation of their respective Services.

(8) Such directors of hospitals, domiciliary facilities, medical centers, and outpatient facilities as may be appointed by the Administrator upon the recommendation of the Chief Medical Director.

(9) Such other personnel as may be authorized by this chapter.

* * * * * * *

§ 4103A. Office of Medical Inspector General

(a) There is established in the Office of the Chief Medical Director an Office of Medical Inspector General.

(b) The Office of the Medical Inspector General shall consist of the following:

(1) The Medical Inspector General who (A) shall be the head of the Office of Medical Inspector General, (B) shall be directly responsible to the Chief Medical Director for such functions as may be assigned to the Medical Inspector General in regulations prescribed by the Chief Medical Director consistent with the provisions of this section, and (C) shall be a qualified doctor of medicine appointed by the Administrator upon recommendation of the Chief Medical Director.

(2) Not less than five Assistant Medical Inspectors General who shall be qualified doctors of medicine, doctors of dental surgery or dental medicine, or registered nurses and who shall be employed on a full-time basis in the Veterans' Administration.

(3) Not less than two registered nurses (including any who are Assistant Medical Inspectors General) who are employed on a full-time basis in the Veterans' Administration.

(4) Not less than one qualified doctor of dental surgery or dental medicine (who may be an Assistant Medical Inspector General) who is employed on a full-time basis in the Veterans' Administration.

(5) Not less than five support personnel, who are employed on a full-time basis in the Veterans' Administration.

(c) The Medical Inspector General shall be appointed for a term of 4 years, with reappointment permissible for successive like periods. The Medical Inspector General shall be subject to removal by the Administrator only for reasonable cause upon the recommendation of the Chief Medical Director.

(d)(1) The Medical Inspector General shall monitor, review, and investigate any adverse incident which is experienced by a patient during the course of the patient's care in a Veterans' Administration health-care facility, including any incident that would not normally be considered a natural consequence of the patient's disease process or illness and any incident that would carry a recognized need for medical intervention.

(2) The Medical Inspector General shall also conduct such reviews and investigations as the Medical Inspector General considers necessary to identify problems in the provision of health care to veterans and, when problems are detected, shall propose to the Chief Medical

Director such corrective measures as the Medical Inspector General considers necessary or appropriate.

(3) The Medical Inspector General shall conduct such other studies, reviews, and investigations relating to the quality of health care provided to veterans as the Administrator or the Chief Medical Director may assign to the Medical Inspector General.

(4) Subject to paragraph (3) of this subsection, the Medical Inspector General shall have sole discretion in determining whether to investigate any incident involving patient care or to study or review any problem in the provision of health care to veterans.

(e) In conducting an investigation of any incident involving the care of a patient or any study or review of any problem in the provision of health care to veterans, the Medical Inspector General shall assign to the investigation, study, or review at least one health-care professional from the Office of the Medical Inspector General.

(f) The Medical Inspector General shall submit to the Administrator, the Chief Medical Director, and the Committees on Veterans' Affairs of the Senate and the House of Representatives a report not later than February 1 of each year, on the activities of the Office of the Medical Inspector General under this section during the preceding fiscal year. The Medical Inspector General shall include in each such report—

(1) a description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department of Medicine and Surgery disclosed by such activities during the preceding fiscal year;

(2) a description of (A) the recommendations for corrective action and of any recommendations for disciplinary action made by the Office during the preceding fiscal year with respect to significant problems, abuses, or deficiencies identified pursuant to clause (1) of this subsection, and (B) the action taken as of the end of such fiscal year on each such recommendation, including any such recommendations on which action had not been completed prior to the end of such fiscal year;

(3) a specification of (A) which activities of the Office were carried out pursuant to an assignment by the Administrator or the Chief Medical Director, and (B) which activities of the Office were carried out on the initiative of the Medical Inspector General;

(4) an identification of each significant recommendation for corrective or disciplinary action described in the report or in previous annual reports under this subsection on which action has not been completed;

(5) a summary of any matters referred to prosecutorial authorities and the prosecutions and convictions which have resulted; and

(6) a summary of each incident in which information or assistance requested by the Medical Inspector General from the Department of Medicine and Surgery during the preceding fiscal year has been, in the judgment of the Medical Inspector General, unreasonably refused or not provided.

(g) The Medical Inspector General shall be an ex officio, nonvoting member of all policymaking bodies within the central office of the Department of Medicine and Surgery that are concerned with

the quality of health care provided in Veterans' Administration facilities or that are concerned with quality assurance in the provision of such care. The Medical Inspector General shall not, however, have any direct responsibility for quality assurance activities, including patient risk management and the reporting of patient injuries under quality assurance procedures.

(h)(1) The Administrator shall transfer to the Office of the Medical Inspector General each fiscal year, out of any funds available to the Veterans' Administration for such fiscal year (other than funds available for the operation of the central office of the Department of Medicine and Surgery), such amounts as may be necessary, as determined by the Chief Medical Director, to support five full-time medical doctors and five full-time support personnel in the Office of the Medical Inspector General.

(2) The positions of five full-time medical doctors and five full-time support personnel in the Office of Medical Inspector General shall be counted against the number of full-time employees authorized by the Office of Management and Budget for the program, function, or activity for which the funds transferred pursuant to paragraph (1) of this subsection would be available except for the transfer of such funds. In the event that the Administrator transfers funds from more than one program, function, or activity, the ten full-time positions shall be counted against the number of such positions authorized by the Office of Management and Budget for each such program, function, or activity in proportion to the amount of funds transferred therefrom.

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SUBCHAPTER V—QUALITY ASSURANCE

§ 4151. Quality assurance program

(a) * * *

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(e)(1) * * *

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(2) The Inspector General of the Veterans' Administration shall allocate sufficient resources (including sufficient personnel with the necessary skills and qualifications) *to the Assistant Inspector General for Health Care Quality Assurance Review* to enable the Inspector General to monitor the quality-assurance program.

(f) The Chief Medical Director shall take such action as may be necessary to ensure that all personnel of the Department of Medicine and Surgery—

(1) are given an explanation periodically of their responsibilities for the quality assurance activities of such department; and

(2) are advised that any failure to comply with quality assurance procedures prescribed in regulations or in procedural publications issued by the Department of Medicine and Surgery, in-

cluding any failure to report any incident as required under such procedures, will result in appropriate disciplinary action.

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VETERANS' HEALTH CARE AMENDMENTS OF 1983

(Public Law 98-160, November 21, 1983)

* * * * * * *

TITLE I—VETERANS' ADMINISTRATION HEALTH-CARE PROGRAMS

* * * * * * *

STUDY OF POST-TRAUMATIC STRESS DISORDER AND OTHER POST-WAR PSYCHOLOGICAL PROBLEMS

SEC. 102. (a)(1) * * *

* * * * * * *

(b) Not later than October 1, [1986,] *1987,* the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the results of the study required by subsection (a). Such report shall contain—

(1) a description of the results of the study;

(2) information regarding the capability of the Veterans' Administration to provide treatment to the number of veterans estimated in such study to be suffering from post-war psychological problems;

(3) descriptions of the policies and procedures of the Veterans' Administration with respect to providing disability compensation for post-war psychological problems;

(4) a description of the activities of the Administrator in attempting to coordinate Veterans' Administration health-care and compensation programs with respect to post-traumatic stress disorder; and

(5) such recommendations for administrative and legislative action as the Administrator considers appropriate in light of the results of the study.

* * * * * * *

MINORITY VIEWS OR MESSRS. MURKOWSKI, SIMPSON, THURMOND, AND STAFFORD ON TITLE III OF S. 1464, THE PROPOSED "VETERANS' ADMINISTRATION BENEFICIARY TRAVEL, QUALITY ASSURANCE, AND READJUSTMENT COUNSELING AMENDMENTS OF 1987"

S. 1464, as reported by the Committee, contains important provisions relating to veterans' travel to and from VA medical facilities and the oversight of VA quality assurance programs. We consider these provisions—which address access to care and quality of care—to be inextricably linked to the VA health-care system. These provisions respond to these issues in a thoughtful and responsible manner.

However, we cannot support the provisions contained in title III of S. 1464 relating to the Vet Center Program. Our objections are strong and premised on both procedural and substantive grounds. Although we fully understand the motivation for incorporating these provisions in S. 1464, we do not believe that the legislative process or veterans are well-served by this action.

A program of readjustment conseling for Vietnam-ear veterans—which came to be know as the "Vet Center Program"—was established in 1979. It was established at a time when it was believed that, due to the nature of the Vietnam War, Vietnam veterans were alienated and would be reluctant to seek services through traditional VA health-care facilities. Thus, a program of readjustment counseling—of a limited duration—was established to provide services through community "store-front" counseling centers which sought to minimize the red tape associated with seeking such services. In reaching a determination on an appropriate timetable for this program, the Committee sought the advice of VA psychiatrists and other mental-health professionals. These experts indicated that veterans with problems associated with combat might not avail themselves of counseling for up to two years following that experience. Accordingly, veterans who requested counseling two years after discharge of release from military service were eligible for counseling under this program.

The Vet Center Program was also intended to be temporary because it established new eligibility for certain veterans and nonveterans to receive certain health-care services—provided directly by the VA or by contract, if necessary—on an outpatient basis. As an adjunct to treatment for veterans, eligibility was extended to family members, and referral services were authorized to be provided to those not eligible, such as veterans discharged on other than honorable conditions. Extending eligibility to these categories was believed by some to be important to the total readjustment counseling process. However, the Committee fully recognized that veterans of all wars, including Vietnam, who may have served honorably in combat and been in need for medical treatment were not eligible for outpatient care generally unless for a condition adjudicated to be service-connected our outpatient care was deemed necessary to "obviate the need" for hospitalization. The Committee never intended to make permanent a program whereby non- veterans, including family members, were eligible for certain services at Vet Centers when those same services would not be available for combat veterans of World War II or the Korean conflict. It was for these reasons that the Committee stated in its Committee Report 96–100 that, " . . . the readjustment counseling program is establishing an entirely new area of eligibility and the Committee believes that proceeding with caution is fully warranted." Given these facts, we believe it prudent that the Committee adhere to its admonition.

Title III of S. 1464, which is derived from S. 1501, would make major and fundamental changes to the Vet Center Program. This title would also effectively make permanent the "storefront" operations through which readjustment couseling services are provided by making it extremely administratively difficult to relocate a Vet Center onto the grounds of a VA medical center. It would do so without any hearings of the opportunity for careful deliberations by the Congress. In addition, those who would be affected by these changes and those who are charged with administering active-duty military and veteran medical-care programs have not testified on this matter. Occasionally, the emergent nature of an issue demands immediate Congressional action. This is simply not such an occasion.

Just a few months ago, the Senate passed legislation, as part of S. 477, to provide the VA with an additional year, through September 30, 1990, to complete the transition whereby readjustment counseling services would be provided primarily on the grounds of VA medical centers as required by current law. Let us be clear, we do expect that the VA will look at each Vet Center to determine the appropriateness of moving the Center onto the grounds of the medical center. In some cases, due to lack of space or distance to the medical center, it may not be wise to move. However, those decisions should be made by the VA—not the Congress.

So, we must ask the question—what is the emergency? Why are we foregoing the appropriate legislative hearing process? The Vet Center Program is not threatened with extinction. Since the inception of the program some eight years ago, the availability of readjustment counseling has not been diminished. In fact, the program has grown far beyond what was envisioned by Congress when this temporary and short-term program was established. This is further evidenced by the fact that at the program's inception the *five year cost was estimated* by the Congressional Budget Office *to be $45 million.* In fact, that is now the *annual* cost of the Vet Center Program.

The American Legion with 800,000 Vietnam veteran members, the Veterans of Foreign Wars with 700,000 Vietnam veteran members, and the AMVETS with 40,000 Vietnam veteran members have formally requested the Committee not to proceed with consideration of these provisions. These organizations—representing the interests of all veterans, including those of the Vietnam era—have asked for time to study the impact of these provisions and to comment on their merits and shortcomings. We velieve that their request is reasonable and should be honored by the Committee. Copies of their letters are included for your consideration.

Additionally, we have several serious concerns—many of which are shared by certain veterans' service organizations—about the substance of the title.

First, S. 1464 proposes to extend eligibility for readjustment counseling services to certain active duty military personnel. We strongly oppose an expansion of eligibility for this VA benefit to individuals who are currently serving on active duty. The Department of Defense is responsible for providing services to these individuals, and it has adequate resources to do so. Additionally, the Secretary of Defense, in an August 7, 1987, letter to Senator Murkowski stated his strong opposition to this proposal. Mr. Weinberger stated, "It is imperative that the Department remain fully cognizant of the psychological status of its active duty personnel. The Military Health Services System (MHSS) maintains a medical record on every active duty person that is annotated each time this member seeks care. By retaining responsibility for providing medical care to all active duty personnel, the MHSS ensures that a complete record of each individual's medical and psychological history is maintained. These records form the basis for medical opinions concerning flight status, fitness for duty, security clearances, and a host of other equally important medical readiness determinations. Should these records be incomplete because medical treatment was provided by another agency, one of these determinations could be fatally flawed."

In addition, eligibility for readjustment counseling would be extended to veterans of World War II and Korea. We believe that these veterans need hospital and nursing home care far more than counseling to "readjust to civilian life." These veterans participated in conflicts many many years ago and, in fact, experience different health and social problems as a result of the aging process. Limited resources should be directed at providing more services to address the needs of an aging veteran population and not on expanding eligibility for Vet Centers and the costs associated with doing so.

S. 1464 also requires that, if a Vet Center is moved onto the grounds of the medical center, the budget remain the same. We ask our colleagues: If the client load did decrease, is it wise to require that the resources for staff remain the same? We think not, especially when veterans are waiting in long lines at the other end of the hospital.

The August 1987 General Accounting Office (GAO) report on the Vet Center Program found several significant problems associated with it. First, the VA has little assurance that Vet Centers provide quality care to veterans. For example, no quality assurance reviews are conducted. Second, the data base which contains information needed to determine workload is questionable. Therefore, it is difficult to determine if client workload data is underestimated or overestimated. For example, 35 out of 100 files which GAO sampled indicated that contact sheets were completed on clients for visits that simply did not occur or when no assistance to the client was provided. Valid workload data is essential if the Va is to determine if a Vet Center is being operated in a cost-effective manner and if staffing levels are adequate. GAO made unannounced visits to six Vet Centers and, in our view, made some interesting observations. During the nine hour work day, the Vet Centers saw between 5 and 17 clients. The average number was nine. The average visit lasted about one hour. Between one and four Vet Center staff members were present during the GAO visit. This staff per client workload is very low. Let us look further into the VA's data as reported by the GAO. Out of a total eligible population of 8.3 million Vietnam-era veterans, since the inception of the program in 1979, the total number of veterans seen has been 305,000. However, of this figure, 11 percent are not Vietnam-era veterans—this group includes World War II and Korean veterans as well as active duty military personnel—and, thus, are not even eligible to receive counseling under this program. Thus, about 271,000 *Vietnam-era veterans* have used Vet Centers. The average Vet Center sees about 486 clients annually. According to GAO, 49 percent of the clients were seen for military-related problems. The remaining 51 percent were seen for problems which, according to Vet Center counselors, were either not related to military service or staff could not determine the cause of their problems. It therefore appears that about 140,000 veterans may have used Vet Centers for military-related problems. Finally, according to GAO, the VA's data base indicated that 56 percent of the Vet Center clients had served in combat. Again, one can conclude that since the program's inception, about 151,760 Vietnam veterans, who served in the Vietnam theater of operations, were seen in Vet Centers. VA's definition of "combat" was defined as service in a "war-zone theatre." This would include service in Vietnam, Laos, Cambodia, and their contiguous waters and air space. However, the Department of Defense has long believed that one out of every four who serves in a "war-zone theatre" actually serves in combat. This being the case, the actual number of combat Vietnam veterans who have been seen in Vet Centers since 1979 may be closer to 37,000.

A report on the effectiveness of the Vet Center Program—conducted under contract with Development Associates, Inc.—was recently provided to the Committee by the VA. Although this study generally found that the program was effective in accomplishing its objectives, the report stated "A staff of three to five persons to serve only one or two new clients per month—as found at a number of Vet Centers—would not seem to be a cost-effective use of limited program resources." Further, the study concluded "The Vet Centers seem to fill an important role as *part* of a network of providers of readjustment and other veterans services. In this role there appears to be room for better alignment with traditional VA organizations in the interest of improving services to veterans." Finally, that same study noted 60 percent of the Vet Center clients mentioned employment related problems most often. We are pleased that the Senate addressed the employment issue as part of S. 999.

Most importantly, we believe it is counterproductive to the psychological well-being of Vietnam veterans to continue to encourage the perception that these individuals have not adjusted to civilian life. Certainly there are some who still need readjustment assistance, but let us not make Vietnam Veterans believe that the people of our Nation and the dedicated employees of the VA cannot understand their needs. That is simply not true.

In conclusion, we can think of no words which can better express the need to proceed with an orderly transition than the very eloquent and powerful statement of the past National Commander of the Disabled American Veterans, Ken Musselmann—himself a very severely disabled Vietnam veteran—"[I]F we establish an official policy that says to Vietnam veterans that they are so different from all veterans of prior wars that services of this type will always have to be provided in a segregated setting, we are encouraging and perpetuating the very things we wish to abolish".

As the Senate deliberates on legislation which would continue to perpetuate a segregated system of services for Vietnam veterans and which could serve to reinforce a false and often self-defeating stereotype of these gallant men and woman, the last of who returned home more than 15 years ago, we urge our colleagues to reflect on the words of Commander Musselmann.

FRANK H. MURKOWSKI,
Ranking Minority Member.
ALAN K. SIMPSON.
STROM THURMOND.
ROBERT T. STAFFORD.

THE SECRETARY OF DEFENSE
WASHINGTON THE DISTRICT OF COLUMBIA

7 AUG 1987

Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator:

This letter presents the views of the Department of Defense with respect to Section 3 of S.1501, 100th Congress, a bill to amend Title 38, United States Code, to eliminate the requirement that the Administrator of Veterans Affairs carry out a transition under which community based Vet Centers would be moved to Veterans Administration medical facilities, and for other purposes.

Section 3 of S.1501 would establish authority for the Veterans Administration to furnish psychological counseling to active duty military personnel who had served on active duty during the Vietnam era or during a period of hostilities. By permitting the Veterans Administration to furnish counseling to assist such persons in "readjusting to active duty" following such service, S.1501 circumvents the primary goal of the Military Health Care System which is to maintain the medical (including psychological) readiness of the active duty force.

The Department of Defense is strongly opposed to the readjustment counseling program provisions of Section 3 as they pertain to active duty personnel. The Department of Defense operates a comprehensive health care system which provides quality psychological counseling to all active duty personnel in need of such care. Further, it is imperative that the Department remain fully cognizant of the psychological status of its active duty personnel. The Military Health Services System (MHSS) maintains a medical record on every active duty person that is annotated each time this member seeks care. By retaining responsibility for providing medical care to all active duty personnel, the MHSS ensures that a complete record of each individual's medical and psychological history is maintained. These records form the basis for medical opinions concerning flight status, fitness for duty, security clearances, and a host of other equally important medical readiness determinations. Should these records be incomplete because medical treatment was provided by another agency, one of these determinations could be fatally flawed.

Accordingly, the Department is opposed to this provision of S.1501 and any provision that would permit the Veterans Administration to provide medical or psychological care to an active duty member except under a formal VA/DoD Sharing Agreement entered into under P.L. 97-174. The Administration continues to support taking advantage of mutually beneficial opportunities for sharing health care resources in accordance with the Sharing Act.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the presentation of this report for the consideration of the Committee.

Sincerely,

The American Legion

[illegible]

July 17, 1987

Honorable Alan Cranston, Chairman
Senate Veterans' Affairs Committee
SR-414 Russell Senate Office Building
Washington, DC 20510-6375

Dear Chairman Cranston:

On review of legislation, S. 1501, which you introduced on July 15, we find ourselves in substantial disagreement over some of the specific provisions. Therefore, we respectfully request a formal public hearing to examine the contents of this legislation. While we are mandated by National Convention resolution to support the "Vet Center" program, the general expansion of it under section 3 (A) and (B) of S. 1501 to include eligibility for counseling for "any veteran or person" is objectionable. The meaning of "or person" in the legislation is without definition in title 38 and we fear it may permit access to the program by dishonorably discharged individuals or others for whom the program was never intended.

A second consideration we believe justifies a hearing is the matter of personnel and fiscal resources that will be required to implement the expansion of the "Vet Center" program. By this we refer specifically to the provision of services by the VA's Department of Veterans Benefits and Department of Medicine and Surgery.

Moreover, in view of the foregoing reservations concerning S. 1501, we must conclude that it would be premature to mark up this legislation at the committee session scheduled for July 23. As always, your attention to the views of The American Legion is appreciated.

Sincerely,

E. Philip Riggin

E. Philip Riggin, Director
National Legislative Commission

VETERANS OF FOREIGN WARS OF THE UNITED STATES

July 21, 1987

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Veterans of Foreign Wars was greatly disturbed with the discovery of your intention to mark up the "Veterans Readjustment Counseling Preservation Act of 1987" this coming Thursday, July 23, 1987. We firmly believe this bill, S. 1501, should have the benefit of a hearing in order to fully explore its merits and/or shortcomings.

As you know, S. 1501 not only counters the intent of current law but redirects the entire thrust of the Vet Center Program. A bill of this magnitude demands careful congressional oversight coupled with the recommendations and concerns of the Veterans of Foreign Wars and other veteran's organizations.

For these reasons, we strongly urge you to refrain from marking up S. 1501 so as to properly allow for a congressional hearing.

Sincerely,

COOPER T. HOLT
Executive Director

cc: The Hon. Frank H. Murkowski
Ranking Minority Member

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

July 30, 1987

Honorable Frank H. Murkowski
United States Senate
202 Hart Senate Office Building
Washington, DC 20510

Dear Senator Murkowski:

During the July 31, 1987, Veterans Affairs Committee "markup" hearing, Senator Frank Murkowski will offer an amendment in the nature of a substitute to S. 1501, The Vietnam Veterans Readjustment Counseling Program Preservation Act of 1987.

As presently drafted, S. 1501 proposes to delete certain language contained in Section 612A, Title 38, USC, and thereby remove the current statutory requirement that, by October 1, 1989, an orderly transition shall have occurred, transforming the current program of readjustment counseling services from one primarily located in centers situated apart from VA medical facilities, to a program primarily located within VA medical facilities.

As we understand the Murkowski Amendment it would, among other things, retain the current law requirement for an orderly transition of the majority of readjustment counseling services to VA medical facilities, however, it would postpone the date for such a transition to be completed until October 1, 1990.

In this regard, the DAV is supportive of an orderly and gradual programmatic transition of VA's Readjustment Counseling Centers into VA medical centers. Accordingly, we favor this aspect of the Murkowski Amendment which seeks to set a timeframe for the accomplishment of the transition.

Our organization has long been and continues to be a strong supporter of VA Psychological and Readjustment Counseling Services for Vietnam veterans. Indeed, the authorization for such services (P.L. 96-22) and subsequent evolution of the VA's "outreach" or "Vet Center" concept for provision of such services were influenced greatly by the DAV's own Vietnam Veteran Outreach Program which had its beginning in 1976.

A decade ago, when recognition and understanding of the post-traumatic stress disorder (PTSD) problems of Vietnam veterans was just beginning to emerge and when Vietnam veterans themselves were filled with feelings of anger, suspicion and bitterness toward government authority and government institutions -- including the Veterans Administration -- it made a great deal of sense to position counseling and readjustment services out of the "traditional" VA setting. The logic -- and it proved to be very sound -- was that Vietnam veterans, distrustful of government authority/bureaucracy, suffering from PTSD and other types of readjustment problems, would be much more receptive to the extension of services in a local community setting.

Indeed, the VA's current program may never have gotten off the ground had it not been physically separated from the traditional setting.

But while the commitment was made to provide these services for as long as they were needed, a history of the program and its development reveals that all who were involved -- the Congress, the VA and the veterans' community -- envisioned that at some point in time, although the need for these services might well continue to exist, their provision in the majority of cases, could be phased back into the traditional setting of VA medical facilities.

The DAV has and continues to subscribe to this scenario.

We believe, from the standpoint of the ultimate reconciliation, readjustment and, if you will, self-acceptance of Vietnam veterans themselves, that it is essential for these services to be phased back if Vietnam veterans shall not, in fact, continue to be alienated or continue to perceive themselves to be alienated from the rest of the veterans' community and society as a whole. In a very real sense, if we establish an official policy that says to Vietnam veterans that they are so different from all veterans of prior wars that services of this type will always have to be provided in a segregated setting, we are encouraging and perpetuating the very thing we wish to abolish.

The national environment and the mindset of Vietnam veterans and many Americans that existed ten to fifteen years ago, that required segregated Vet Centers if the program was to work at all, no longer exists today...signs of this are everywhere: the attraction of the Vietnam Veterans Memorial to millions of Americans, the plethora of movies and books about Vietnam and televised fund raising tributes are recent indications of an ongoing and healthy national reconciliation process. We would submit the attitudes and self-image of Vietnam veterans themselves have been and continue to be improved.

In short, the appropriate and orderly "phase back" of the majority of readjustment and counseling services for Vietnam veterans to a VA hospital setting is an attainable goal, born of sound policy, and should not be abandoned. The DAV does not support any change of current law that would deter us from such a goal or fundamentally alter such a policy.

We therefore urge that you and other members of the Committee strongly support this portion of the Murkowski Amendment to S. 1501.

Sincerely,

K G Musselmann

KENNETH G. MUSSELMANN
National Commander

KGM:am

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ATIONAL LEGISLATIVE DIRECTOR

July 20, 1987

The Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Chairman Cranston:

The American Veterans of World War II, Korea and Vietnam (AMVETS) wishes to respectfully comment on the proposed bill: "Vietnam Veterans Readjustment Counseling Program Presentation Act of 1987" introduced by yourself together with Senators Matsunaga and Kerry.

While AMVETS is supportive of the Vet Centers' concept and their unique ability to deliver needed psychological services to Vietnam Era Veterans, we believe that the proposed "Act" needs to be at this time more fully aired and debated. There is scant time for AMVETS to fully review the merits of the "Act", especially Section 3, in order to make an informed decision.

AMVETS, therefore, cannot at this time support the Act until we have had time to fully review the Act's implication with respect to the Vet Centers.

Thank you for allowing AMVETS the opportunity to express its views.

Sincerely,

David J. Passamaneck
National Legislative Director

DJP:JGB:pjf

bcc: **Chris Yoder, SVAC**
Donald Ivers, GC, VA
James DeWire, VA
Charles Flora, VA

American Veterans of World War II, Korea and Vietnam

NATIONAL CAPITAL OFFICE
NCOA
225 North Washington Street • Alexandria, Virginia 22314 • (703) 549-0311

July 28, 1987

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
414 Russell Senate Office Building
Washington, D.C. 20510-6375

Dear Mr. Chairman:

The Non Commissioned Officers Association (NCOA) is deeply concerned about the provisions of S.1501 and your amendment No. 610 which would extend psychological readjustment counselling benefits through vet centers to active duty servicemembers. While NCOA appreciates the obvious concern this legislation expresses for active duty servicemembers, we believe it is likely to create substantial problems.

Both the physical and mental health of members of the armed forces are critical to military readiness. Accordingly, the military provides a full support network (including individual and family counselling) to meet the health needs of service personnel and to identify individual health problems which may adversely affect readiness or safety. Extending psychological counselling to active military personnel outside this monitored system could have a devastating effect on readiness and the safety of both the member and his unit. It would be most tragic and unfortunate to allow this to happen.

NCOA urges you to withdraw the provisions concerning care for active duty military personnel from S.1501. Thank you for your consideration.

Sincerely,

Dick

Richard W. Johnson
Director for Legislative Affairs

RWJ/car